THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. XI, No. 1 | 1957 | January-February

O.T. Dept.

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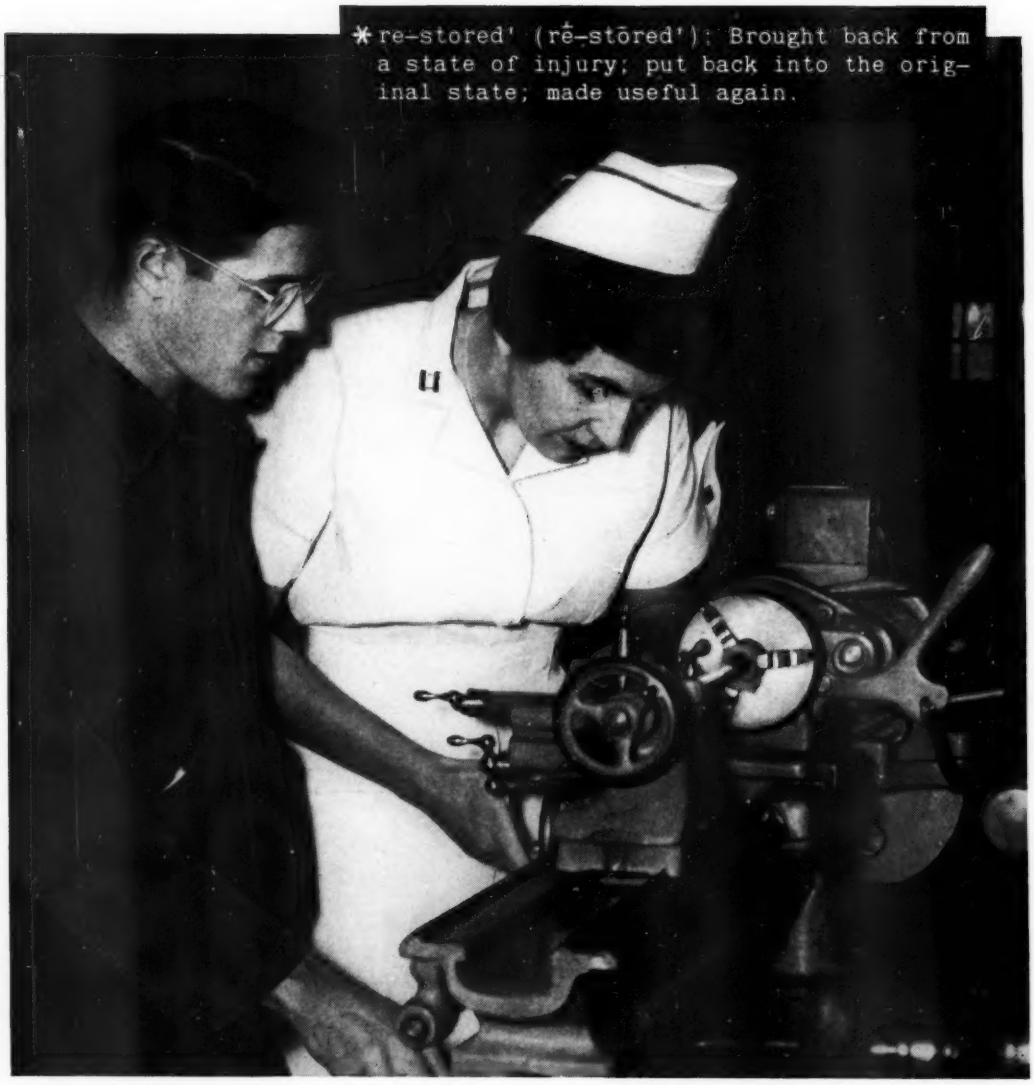

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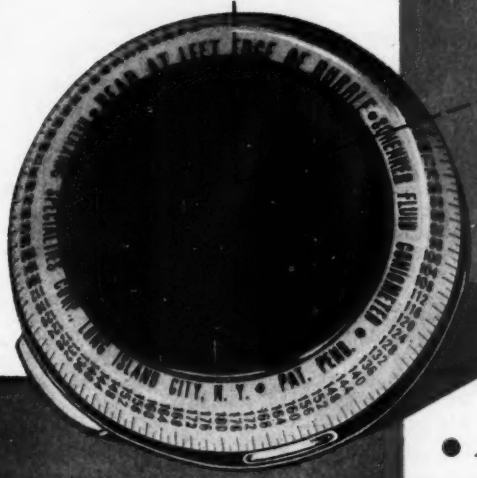

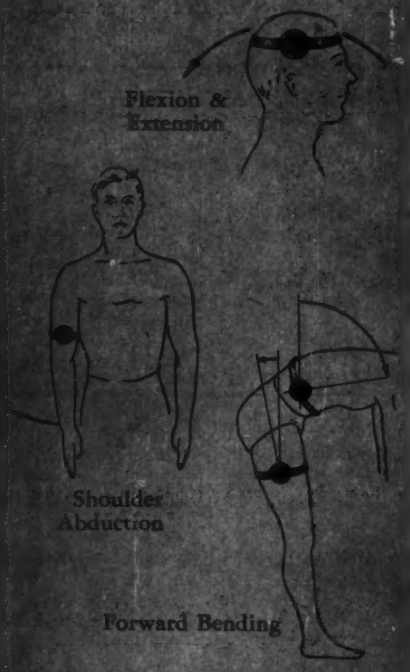

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The American Journal of Occupational Therapy

The Official Publication of the

American Occupational Therapy Association

Editorial Office: 3514 N. Oakland Ave.
Milwaukee 11, Wis.

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The Journal is published bimonthly on the 10th of February, April, June, August, October and December.

Subscription price to members included in yearly fees; to non-members $5.00 a year domestic, $5.50 foreign. Single issues, $1.00.

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THE AMERICAN JOURNAL
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OCCUPATIONAL THERAPY
Official Publication of the American Occupational Therapy Association

January-February 1957 Vol. XI. No. 1

A PARTIAL FIELD SURVEY OF PSYCHIATRIC OCCUPATIONAL THERAPY*

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In recent years there has been growing evidence of the necessity for reconsideration of some of the basic premises and techniques of occupational therapy in psychiatric hospitals. It has become apparent that too much emphasis has been put upon the diversional and occupational aspects of activities to the neglect of psychodynamic problems of the individual receiving occupational therapy. Although the importance of diversion and satisfaction in achievement is beyond doubt, the values of objects used or created as indicators of unconscious happenings seem to have been by-passed too often for the sake of appeal to the consciousness of the patients.

The above contentions can be substantiated by a quick glance at almost any textbook of occupational therapy. Colson in his text, *Rehabilitation of the Injured,* states: "In mental conditions the aim (of occupational therapy) is accomplished by selecting an occupation which will engage the mind and reeducate its normal functions."[1] According to Haas' textbook the "first mission" of occupational therapy is "to create a modified normal atmosphere in which the patient may spend part of his time. The normal atmosphere of the average person is that of work activity."[2] This statement disregards the fact that the patient may have been hospitalized for the very reason of his inability to cope with the "normal" atmosphere of the outside world.

The following statement by Pattison is often quoted in different texts as a definition of occupational therapy: "Occupational therapy is any activity, mental or physical, *definitely prescribed and guided* (Italics ours) for the distinct purpose of contributing to and hastening recovery from disease or injury."[3] The general aspect of this proposition may be attributed to the nebulous character of its underlying concept. It is difficult to conceive how one can prescribe "definitely" for such labyrinthine complexities as mental disorders. In the present state of our knowledge, it seems unlikely that one can prescribe healing activities as one does healing medications. In this connection we find in a book entitled *Prescribing Occupational Therapy,* the following statement: "it seems unnecessary to attempt an analysis of the psychological processes in man in order to determine why occupational therapy is of benefit. By experience, empirically, we already know that much good may follow its use."[4] The author of this statement demonstrates further his peculiar understanding of psychological problems by stating: "The first mental objective to be attained is usually improvement of the patient's mental attitude and morale . . . the production of a well made, useful and attractive article, or the accomplishment of a useful task . . . gives the greatest satisfaction and thus produces the most beneficial effects."[2]

Another frequently used text, which seemingly deals with the "theory of occupational therapy," categorically states that "the aim of an occupational therapy department in a mental hospital *should be to employ* (Italics ours) every patient in the hospital who is capable of, or can be made capable of employment . . . the purpose of an occupational therapist in treating cases of mental disorder is to provide means for the *reeducation* (Italics ours) of those functions of mind which are either not functioning or are functioning abnormally."[5] One dimly visualizes the prospect of a reform school under such a

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*This project was subsidized by a Dominion-Federal health grant. The authors acknowledge their deep gratitude to the directors of mental hospitals, to psychiatrists and occupational therapists whose kind cooperation made this study possible.

philosophy. In still another widely read textbook, in the chapter on "Scope of Occupational Therapy," we read: "Neurotic tendencies can be dissipated by planned activity for gratification through accomplishment . . . day dreaming and fanciful thinking may be interrupted or replaced by an active interest in a work project . . . lack of confidence or loss of ego can be overcome by the development of assurance through actual demonstration of ability by performance."[6] The authors also say "occupational therapy must provide a diversity of activities using new and sometimes handsome materials."[6] The two co-authors of the above text who have compiled the chapter on "Occupational Therapy for Mentally Ill," are aware of the importance of psychodynamic considerations in occupational therapy, but this awareness is crowded out by what appears to be the yoke of the traditional point of view, or an unconscious fear of abandoning this well established authority reference. They do not analyze the dynamic vicissitudes of an activity. Their whole program is directed toward the consciousness of the patient, and their conception of psychopathology seems to be a common sense psychology of consciousness: if the patient is guilty, relieve his guilt; if he is withdrawn, bring him into a group and make him contact, etc.

Examples such as these can be multiplied, but suffice it to say that the underlying principles of most of the recorded theories of occupational therapy seems to be the assumption that by diverting the patient from his fantasmic preoccupations, and by normalizing his environment (normal according to an unidentified standard) he will abandon his fantasies and undertake a "normal" occupation. Excluding a few recent attempts to approach occupational therapy from a dynamic point of view,[7,8] even the most recent and enlightened text, exclusively written for psychiatric occupational therapy[9] shows this underlying intention of solely strengthening the ego in occupational therapy activities. Fidler and Fidler make an important contribution in pointing out the value of occupational therapy as a psychotherapeutic tool, and the necessity of setting up activities according to the patient's emotional needs. However, their elaboration of these themes is relatively inconsistent and lacks linking concepts. This is evident, for example, in their choice of headings for the "specific objective" of occupational therapy. In this choice ("hostility," "obsessive-compulsive," "needs to excel," "narcissism," etc.) symptoms, dynamics and phenomenology are mixed, reiterated and used interchangeably. Another fundamental error in their conception is the equation of overt with covert needs. They do not mention the possibility that the overt need may be an ego-defense. If the patient shows an overt dependent need, his dependency, according to the above authors should be gratified; if he is aggressive, the means to fulfill this aggression should be provided, etc.

We have chosen, in this introduction, examples from some of the leading texts of occupational therapy because they form the background source for its teaching. It should be noted here that our purpose in the above discussion is not, and throughout this paper will not be, the depreciation of the importance of ego-strengthening, diversion and occupation in occupational therapy. If we emphasize the dynamic aspects of occupational therapy and insufficiencies of the present concepts, it is because the attention until now has been predominantly focussed upon the ego-strengthening function of occupational therapy. To make the point clearer we stress the dynamic point of view without, however, forgetting the value of the current point of view.

In order to obtain some information about the extent of dynamic orientation of occupational therapy, and the degree of participation of occupational therapists in the therapeutic team, it was felt that a field survey of some leading psychiatric centers would be of some benefit. It was thought that the operational evaluation of occupational therapy, as it is being practiced, would determine the extent of theoretical formulations concerning dynamics of human activities which underly these practices. The following account is the result of such a survey. However, it should be emphasized that the conclusions are not, for obvious reasons, applicable to all centers of psychiatric occupational therapy. The survey was a limited one. The inferences derived from the data transcend in many respects and become meaningful only in the general conceptual framework of dynamic psychopathology.

MATERIAL AND METHOD

The field study consisted of the survey of 15 major psychiatric centers in Canada and parts of the North-Eastern United States. Observations were made at three levels: the patient, the occupational therapist and the psychiatrist. The technique was that of a personal interview which evolved more or less, particularly at the level of the occupational therapist, around a questionnaire (Appendix 1). The questions were put casually and the information obtained in a non-directive fashion.

In addition some information was obtained from the report of the psychiatric committee of the Canadian Occupational Therapy Association, September 13, 1955.

All in all 50 patients, 22 psychiatrists and 21 occupational therapists were studied.

RESULTS

We shall discuss the significant information derived from the survey from the three levels of observation mentioned above.

1. *At the patient's level.* Of 50 patients studied 21 were schizophrenics, 13 manic-depressive, and 16 neurotics. The schizophrenic group consisted of 13 ambulatory, relatively acute and eight chronic long term hospitalized patients. Among manic patients none were in an acute state.

The verbal response to the inquiry about occupational therapy in all cases was surprisingly uniform, and could be understood as ego directed. Forty-two patients stated that occupational therapy "helped pass time," "keeps you busy," "occupies your mind," "you are occupied with something" and other similar answers. One neurotic patient was "happy to learn some handicraft." Eight chronic schizophrenics did not care to comment on the questions asked. The majority of the patients showed much interest in occupational therapy, were eager to participate in the activities offered to them and felt that occupational therapy brought them "relief." However, they were perplexed about the purpose of these activities, and many of them had a feeling that occupational therapy had little to do with their treatment, since "the doctor was not there."

It seemed that non-verbal, abreactive phenomena which could have been of some benefit for some patients were not integrated within their psychological or somatic treatment in a comprehensive manner. It became apparent that unless an activity or a production was used specifically for uncovering of unconscious processes, the function of the activity or the production could not extend beyond the diversional field regardless of the relative value of these phenomena in the patient's immediate experimental field, or a haphazard interplay of unconscious processes in nonverbal experiences. An example may illustrate this point. A chronic, mute, female schizophrenic made with plasticine what appeared to be many prehistoric reptiles. The previous behavior of this patient allowed us to interpret these productions to her as projections of threatening internal objects ("These animals are within you, you want to destroy me or part of me. You are afraid of being afraid of your internal animals," etc.).

This interpretation resulted in the making of a large number of these animals by the patient. This phenomenon and a partial change in the patient's behavior indicated a decrease in her anxiety arising from her destructive impulses, although her destructive trends were never apparent in her overt behaviour.

This example may illustrate the value of exploring the dynamics of seemingly diversional activities.

2. *At the occupational therapist's level.* A total of 21 occupational therapists was interviewed. Thirteen amongst them were the heads of occupational therapy departments in psychiatric centers, and four were teachers of schools of occupational therapy. The interviews were based mainly upon the questionnaire mentioned above. The data obtained could be analyzed under four general headings: the meaning and function of occupational therapy; the role of media; the theoretical framework of occupational therapy; the occupational therapist-psychiatrist relationship.

a. *Meaning of function of occupational therapy.* Table I summarizes the number of answers given by different occupational therapists in response to the request to define the meaning and the function of their field of activity.

It should be noted that many times one individual gave several of the aforementioned concepts as answers to the inquiry. Our purpose in presenting this table is to show the relative importance of a variety of concepts which, consciously or unconsciously, determine the role of occupational therapy in the setting. In the table we have included concepts explicitly mentioned and elaborated upon and have omitted all implicit formulations which are dealt with under the heading "Theoretical Framework," e.g., the concept "to improve the patient" is obviously intended or wished, at least consciously, by all occupational therapists; however, only four individuals explicitly stated that the function of occupational therapy was to improve the patient.

The analysis of the data, and the recording of the immediate impressions after each interview as to the depth of the understanding of the interviewee in regard to the psychodynamic aspects of human organisms, led to the conclusion that except for one instance ("to facilitate sublimation") occupational therapy was conceived as a means to (1) divert attention from fantasy and inner preoccupation; (2) to produce a "normal" atmosphere for a "pleasant occupation," and (3) to socialize. In brief, occupational therapy was conceptualized as an instrument of ego-strengthening through two main mechanisms of defense, namely repression and forced suppression. By forced suppression is meant an external temporary imposition of an artificial behaviour, in contrast to the sub-clinical reorganization of the ego-system which occurs in dynamically oriented psychotherapy. Overlooked were the facts that the inability of the patient's ego-system to control the emergence of needs (in action or in fantasy) may be responsible for his incapacity to live "normally;" that his retreat from reality may be due to his anxiety about this very socialization that

therapists want to force upon him; that the preponderance of fantasies and restitutional activities may be the sole manner of adaptation remaining for the patient to integrate his ego-system and his need-systems.

It should be noted that the statement (often quoted in textbooks) "occupational therapy provides an outlet for excess energy" has only an appearance of dynamism. In fact, in the practice of occupational therapists, it amounts simply to allowing the patient to indulge in a behaviour, which he overtly manifests, in a permissive manner and in a permitted form. The only example of this kind of affect release which could be given is that of condensation and displacement of aggressive drives; if the patient is aggressive muscular activities are prescribed which are supposed to act as a safety valve. This notion of "excess energy" is rather superficial and almost naive, it does not take into account unconscious tension resulting from imbalance between need and discharge, conflicts between the different psychic systems and different phantasied object-relationships.

Another concept which may convey a note of dynamic nature is that of "establishing contact." The study of the data reveals that the establishment of contact meant the introduction of a patient into a group setting, i.e. the offer of a group which may or may not consist of kindred spirits. The problem of the nature of this introduction and dynamics of transference (individual and group) were hardly ever considered.

b. *The role of media.* For eleven persons the media had a secondary role (secondary to the attitude of the therapist) for two an important role, and for the rest it had no particular meaning or importance. In general the function of the media was identified with that of occupational therapy itself, i.e., to divert, to normalize, to socialize and to facilitate the relief of excess energy. No or little regard was given to:

(1) The problem of the symbolic significance of created objects.

(2) The problem of object relationships in general, and the fact that created or chosen objects may be used as means of projecting intolerable impulses, painful feelings and objectionable attitudes.

(3) The problem of the facilitatory effect of created or chosen objects on the uncovering of drives, defenses and transference phenomena. The overlooking of these and many other considerations appeared to be related to the lack of an all embracing theory of dynamic occupational therapy, which we shall discuss presently.

c. *Theoretical framework.* In this connection the unanimously expressed opinion was that there was no theory of psychiatric occupational therapy, i.e., a relatively coherent and consistent system with adequate linking concepts constructed to explain and to interpret the phenomena occurring in occupational therapy, and to serve as a guide for activities to be beneficially employed. It appeared that this vacuum was due to the fact that occupational therapy had not incorporated and assimilated the dynamic point of view of the present psychopathological theories, particularly in regard to the concept of object-relationships of psychoanalytic psychology. Except for three occupational therapists who had some information about the dynamic point of view, there was a relative unawareness of the meaning or the use of such terms as "psycho-dynamics," "unconscious processes," "object-relationships," etc. To the question "what do you understand by the terms "unconscious processes" and "psycho-dynamics" a teacher of occupational therapy answered: "unconscious? . . . a lot of Freudian theories . . . is that what you want me to say?" A head of the department of occupational therapy, when asked about the existence of any theory of occupational therapy, stated: "An occupational therapist cannot have any theoretical framework. She should follow the doctor's. (Do the doctors have any theory of occupational therapy?) . . . Well . . . I don't know." A chief of a department of occupational therapy answered to the question "what do you understand by 'object-relationship'"? "Oh, my goodness . . .," and another one: "Oh, dear me." Although the above two quotations are two extreme examples, we infer from our observations that the level of understanding of dynamic psychopathology, by and large, is low among occupational therapists.

The present survey demonstrates that: (1) there is a lack of satisfactory autonomous theory of occupational therapy (dynamic or otherwise); (2) there has been no systematic attempt to incorporate coherently present theories of dynamic psychopathology, particularly psychoanalysis, into the occupational therapy framework.

These two points probably account for difficulties in other aspects of occupational therapy, e.g., the absence of combined therapeutic effort with psychiatrists (one moves on a different plane from the other), the constant complaint of lack of liaison between occupational therapists and psychiatrists, and the gradual decline in interest shown in psychiatric occupational therapy, at least as far as Canada is concerned.

d. *Occupational therapist-psychiatrist relationship.* Of twenty-one occupational therapists interviewed, seventeen indicated that, in general, there was no close liaison between an occupational therapist and the psychiatrist. In four cases where the occupational therapist said that there was a satisfactory relationship with a psychia-

trist, who was "cooperative," under further inquiry it became apparent that this cooperation meant the writing of a prescription (indicating the history and phenomenology) by the doctor and his coming to the department from time to time to see what the patients "were doing."

When asked about the causes of the lack of occupational therapist-psychiatrist relationship, the following answers were given: "The doctor does not know much about occupational therapy" (9 instances); "The doctor is not interested" (2 instances); "The doctor is only interested in seeing that the patient is doing something" (2 instances); "For the doctor occupational therapy is just a hobby shop" (2 instances); "The doctor just says 'keep them busy'" (4 instances); "The doctor fails to convey to the patient that occupational therapy can be a part of his treatment" (1 instance); "The attitude of the doctor is that of puzzlement about what occupational therapy can do" (1 instance).

Our survey indicates that without exception all occupational therapists were willing to cooperate with and learn from the psychiatrist. They responded with great enthusiasm to the cooperative attitude of the psychiatrist. However, their enthusiasm was dampened by the following factors: (1) inability to operate on the same conceptual plane as dynamically oriented psychiatrists, which may lead to anxiety regarding incompetence, injury to self-esteem, uncertainty of prestige, dissatisfaction and unhappiness with subsequent withdrawal. (2) Fear of the mentally ill. To most occupational therapists interviewed, mental disorders appeared as something nebulous, queer and incomprehensible. This feeling should be interpreted in part as the projection of the occupational therapists' own attitude, motivated by anxiety of confrontation with a symbolically perceived danger situation. This feeling also could explain the natural tendency of new applicants in occupational therapy to drift toward the field of physical disabilities which offers seemingly concrete and known situations, manageable through definite rules and standards. Similar observations were made in the survey by the Canadian Association of Occupational Therapy, where it was found that for the majority of occupational therapists, mental disorder was something hopeless. (3) The above mentioned anxiety, in several centers, was accentuated by some psychiatrists' lack of knowledge of occupational therapy resulting in a defensive attitude of denial and rejection in them.

3. *At the psychiatrist's level.* What do psychiatrists know about occupational therapy? What is their attitude towards it? And what do they think of its application and its therapeutic value? To answer those questions twenty psychiatrists were interviewed informally. Many of them were among the leaders in the field, and the majority of them were medical directors of mental hospitals.

The survey revealed that the role of the psychiatrist, degree and mode of his participation, and his level of interest in occupational therapy was dependent upon (1) his knowledge of dynamic psychopathology, particularly his conception of creativity, play therapy and object-relationships; and (2) his knowledge of and insight into group psychodynamics.

In accordance with the above two considerations, psychiatrists, in their attitude toward occupational therapy, could be divided into three categories:

(1) Those with relatively little knowledge of dynamic psychopathology. For these psychiatrists the department of occupational therapy appeared to be a place where the patients are kept busy and occupied. They used occupational therapy as a means of breaking the monotony of the long and weary hours between treatment procedures and meals. In view of its limited objective the job of an occupational therapist in a setting of this kind can hardly be regarded as intellectually stimulating. Her prestige in the therapeutic team is low. Some of these psychiatrists intensified the anxiety of the occupational therapist as to the effectiveness of his role.

(2) Those with moderate knowledge of dynamic psychopathology. Each of these psychiatrists had, more or less, formed a personal conception of occupational therapy, if or whenever they used it. There was no uniform conceptual framework, and the main formulation in general included expression, canalization and sublimation of aggressive drives.

(3) Doctors with considerable knowledge of psychodynamics. The majority of psychiatrists in this category did not use occupational therapy at all, but concentrated their major effort on psychotherapy. There was only one psychoanalyst among this group who utilized occupational therapy as a means of diagnosis, uncovering unconscious processes, and particularly as an indicator of change in patients' psychotherapeutic progress. Needless to say dynamically oriented psychiatrists can do most for the development of dynamically oriented therapy.

COMMENTS AND CONCLUSIONS

It is evident that due to the relatively small number of psychiatric centers (15), occupational therapists (21), psychiatrists (22) and patients (50) which form the basis of this report, no sweeping conclusions can be drawn. However, because the occupational therapists and psychiatrists interviewed are among the leaders in the

field, it seems justifiable to formulate some conclusions at least as far as the present status of occupational therapy in Canada is concerned.

Before doing this we would like to reiterate that far from depreciating the valuable work which has been done by occupational therapists, it is our intention to show some of the shortcomings of present occupational therapy and to widen its scope by incorporating psychopathological concepts into its teaching and practical application. As happens so often in rapidly growing disciplines there has been a time lag between the development of modern psychiatry and the development of occupational therapy. It is possible, in our view, to bridge the hiatus which at present exists.

Basing ourselves on the above considerations and considering that our inferences from the data take their significance by reliance on dynamic psychopathology, the following difficulties can be stressed:

(1) The lack of a theory of occupational therapy. There is no fundamental conceptual framework which includes the present knowledge of dynamic psychopathology and encompasses comprehensively the field of psychiatric occupational therapy. Lack or absence of basic concepts makes itself felt more markedly in interviews with occupational therapists than in a study of the textbooks which they use. The latter superficially may give the impression of some background hypotheses.

(2) The weakness of the liaison between the occupational therapist and the psychiatrist. The relative lack of occupational therapist-psychiatrist relationship is partly due to the anxiety aroused in the occupational therapist because of the weakness of her position in a theoretical field, and partly due to the anxiety of some psychiatrists because of their difficulty in performing the role of authority expected from them.

(3) The emphasis placed upon ego-strengthening. At the present time the major function is defined as the strengthening of the ego's defences of suppression and denial, not as an emerging autonomous ego reorganization, but as a forced, externally imposed mode of behaviour.

(4) The relative decline of interest in occupational therapy. It is felt that occupational therapy is suffering from what can be designated a concept-deficiency disease, which may be remedied by an infusion of a dynamic orientation with the aim of establishing linking concepts.

Our preliminary trials made in this direction[8,10,11] have indicated that the following considerations may be valuable, and may contribute to the construction of a theory of occupational therapy and the formulation of a technique:

(a) From the theoretical point of view if it is thought feasible to construct a relatively autonomous psychiatric theory of occupational therapy, this should have as its *point of emphasis* the dynamics of object-relationships. Objects, created or selected, are the central core of activities in occupational therapy settings. They should naturally and logically have a major positional value in the systematic whole of any theory of occupational therapy. If objects and their symbolic vicissitudes are foresaken, and the emphasis is put solely upon the attitude of the patient and the transference phenomena, occupational therapy will become identical with group psychotherapy and there will be no need to have objects in the therapeutic setting.

(b) Two procedures, among others, appear to offer valuable possibilities: art therapy and play therapy.

Art therapy has been increasingly used in individual[12,13] or group[11] setting. By "art" we mean the spontaneous, free creation in a psychotherapeutic situation where these creations are used for the uncovering of drives, defences and transference phenomena. We have discussed such a method of treatment elsewhere.[11]

Play therapy has been utilized in psychotherapy of children for several years. It may prove of great value in the treatment of mentally diseased adults, especially schizophrenics. By play therapy we mean either the free making of objects or spontaneous attribution of roles to different toys in a situation where this free play, like free association, is used for the therapeutic uncovering.

(c) From an operational point of view it is evident that the above two considerations can be applied only by those occupational therapists who have had intensive training in psychopathology and psychotherapy. This will lead to the inevitable recommendation that in order to institute a dynamic orientation in occupational therapy a relative reappraisal and revision of the present college training programs of occupational therapy in some centers is a necessity.

This by no means implies the abandonment of the valuable information already in operation, but a revaluation of the existing methods and concepts which may lead to the deepening of our understanding of occupational therapy, and, perhaps, the construction of a more comprehensive and autonomous theory of dynamic occupational therapy.

TABLE I

Meaning and Function of Occupational Therapy

Concept	No. of Answers
To improve the patient	5
To do something	1
To divert	4
To make the patient useful	5
To provide a normal atmosphere	7

To enhance reality thinking 8
To do something constructive 5
To increase concentration and confidence 4
To socialize 9
To provide an outlet for excess energy 9
To establish contact 2
To help the diagnosis 4
To facilitate sublimation 1

APPENDIX I

QUESTIONNAIRE

1. What does occupational therapy mean to you, and what is the function of occupational therapy?

2. In your experience, what does occupational therapy do for the patients, and what is its mechanism of action?

3. How do you apply occupational therapy? How do you start with a patient? Do you follow him, and do you note his serial activities, if any?

4. Do you think that the nature of media in occupational therapy is of any importance? If so, to what extent and why?

5. Why do you think some patients willingly accept occupational therapy and others not?

6. How would you deal with patients who refuse occupational therapy?

7. What is the theoretical framework which guides your activities in occupational therapy?

8. Do you think that the present theoretical framework of occupational therapy as applied to mental illnesses is adequate? If not, what are, in your opinion, inadequacies?

9. How do you suggest we remedy these inadequacies?

10. In your opinion, what is (are) your textbook (books) of choice in occupational therapy? Give your reasons.

11. What is, or has been, the general attitude of the psychiatrists towards occupational therapy?

12. What is, or has been, the general attitude of the patients towards occupational therapy?

13. Do you feel that the liaison between psychiatrists and occupational therapists is satisfactory? If not, in which respect is it lacking?

14. What do you think the psychiatrists expect from the services of occupational therapy?

15. What is, or has been, the general attitude of nurses toward occupational therapy?

16. What is, or has been, the general attitude of non-psychiatric occupational therapists toward occupational therapy as it is being practiced in mental hospitals?

17. Do you regard the prestige of occupational therapists as high or low? If low, why?

18. What do you understand by the terms "unconscious processes" and "psychodynamics"? Do these concepts guide your approach to your patients?

19. What do you understand by "phantasy" and "object relationship"?

20. What prompted you in the choice of occupational therapy as your profession?

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THE ROLE OF OCCUPATIONAL THERAPY IN A MULTI-DISCIPLINE APPROACH TO PSYCHIATRIC ILLNESS*

GAIL S. FIDLER, O.T.R.

It is the purpose of this paper to define the role of psychiatric occupational therapy as it relates to other disciplines in psychiatry and to present those functions of occupational therapy which are most closely related to and dependent upon a give and take relationship with the psychiatrist, the social worker, the nurse and the clinical psychologist. Any such attempt is based on the concept that effective communication can appreciably enhance therapeutic endeavor and that meaningful communication is contingent upon an understanding and appreciation of our particular roles in treatment as well as those functions we share with others.

In discussing the role of occupational therapy in psychiatry I shall touch upon some of the concepts and techniques shared by all disciplines in a treatment setting as well as those more specifically associated with occupational therapy. It will be apparent that in some instances our functions are identical, with differences only in the techniques used to accomplish the function. Again there will be instances where there is little or no difference in goal or function or in the way it is carried out. Whatever the similarities or differences, implicit in the adequate functioning of occupational therapy, as one approach to modifying or changing behavior and feeling, is the interdependence of all disciplines.

In recent years there has been an increased awareness that the problem of psychiatric illness is one so complex that no single discipline or technique can be expected to provide all the answers. We now recognize that if significant inroads are to be made in the treatment of emotional illness we must bring together the thinking of numerous persons representing the many and varied disciplines in the study of human relationships. Concomitant with the growth of this concept there has developed a finer appreciation of the impact of one person on another and on the group, with increased skill in and knowledge of individual and group interaction.

When a multi-discipline approach is used in treatment we come face to face with the many problems involved in group dynamics. We become aware that in order to work together as a group we must be able to communicate in a satisfying manner with one another. A most necessary ingredient for effective communication is an understanding and appreciation of one another as human beings, as well as appreciation and understanding of the particular skills and techniques within a given discipline. In addition, it seems to me that acceptance of others as integral participating members of a treatment team is contingent upon knowing what concepts we share in common. Too often we lose sight of the fact that we do and must share many goals and many basic concepts relative to our patients' welfare, and we speak of over-lapping functions as having a detrimental effect on the total treatment plan. It is those principles and functions which we share that are perhaps the solid foundations for effective communication and interaction.

Occupational therapy may be defined as that form of psychiatric or psychologic treatment which uses constructive activity and the relationships developed around these activities as the mode of operation. Activities used as treatment provide an almost unique situation in which the patient as an active participant can deal with his actions as well as his feelings and thoughts. In hammering a copper tray or stamping his feet in a circle dance, the patient can not only experience certain feelings but can almost see these feelings at work in a reality situation. Occupational therapy provides the patient with a laboratory for living, a situation in which he can learn and practice new skills in living, experiment in a give and take relationship with others, utilize insights gained in psychotherapy, and learn and test more effective means of communication.[1]

Within this frame of reference occupational therapy may be said to have a four-fold purpose, (1) to make valid contributions to the milieu of the hospital community, (2) to augment formal psychotherapy or psychotherapeutic efforts, (3) to provide factual data for use in evaluations and diagnosis and (4) to assist the patient to

*Paper presented to the staff of the Nebraska Psychiatric Institute, University of Nebraska, March 16, 1956. Many of the concepts presented here are not essentially my own but represent the combined thinking of friends and colleagues with whom I have thought and worked, and particularly those members of the committee on psychiatry, American Occupational Therapy Association, who have attempted to more clearly define the role of occupational therapy as a therapeutic measure and to bring about more effective communication among ourselves, with our associates and with our patients.

undertake appropriate economic and social responsibilities.[2]

All of us are active participating members of a hospital community, both as human beings and as representatives of particular professions. Our participation with co-workers and patients in the daily living experience within a hospital is an integral part of the structure of that institution. The part we play in the "feeling tone" of the hospital, our obligations to ourselves and our patients in this respect cannot be overemphasized. The function of occupational therapy in the hospital community is similar to that of nursing, social service, psychological service and others, although the particular role may be perceived as different in terms of the techniques used. By utilizing individual and group activity programs occupational therapy supports and contributes to the establishment of an atmosphere conducive to recovery and helps to create a feeling that living with others can be a less threatening and less forbidding experience.[3] Working with other members of the psychiatric team the occupational therapist assists in the development of tolerance and respect for individual needs and differences, facilitates normal interests and relationships, and aids in creating an awareness that new patterns of behavior and relationships can be learned. None of these can be accomplished by occupational therapy alone, and only with increased self knowledge, appreciation and understanding of others and their contributions can we realize such goals.

The second purpose of occupational therapy in a treatment setting is to augment or supplement formal psychotherapy or therapeutic efforts of the hospital staff on behalf of the individual patient. Here again we share a common goal in providing opportunity for the patient to find satisfaction of his basic need for security—to be loved, accepted and to belong. By skillful utilization of activities and the concomitant relationships, the occupational therapist structures situations which provide opportunity for the therapeutic expression of emotional needs and drives.[4] Several factors are implicit when activities are used as an integral part of the therapeutic process to modify or bring about changes in behavior and feeling. While the development of a therapeutic program for a given patient is arrived at by cooperative endeavor of all persons concerned, the major responsibility for determining which therapeutic measures and techniques are indicated rests with the psychiatrist. The occupational therapist relies heavily on the psychiatrist for guidance and information relative to treatment goals; the particular needs of the patient; which of these may be dealt with most satisfactorily through sublimation or through a more direct expression; the nature of the transference relationship and how this may be used to bring about change. Increased communication in this area is necessary in order that occupational therapy procedures may be more closely related to procedures in psychotherapy and that there may be an increased mutual understanding of the patient's problems, and cooperative endeavor on the part of the patient, the psychotherapist and the occupational therapist in dealing with problems.

One source of information relative to unconscious needs and drives is the clinical psychologist. Material available from projective tests is invaluable to the occupational therapist and can be almost directly translated into activity plans for the patient. For example, data from the Rorschach test about the patient's use of color, form and movement; how he handles impulses; how he perceives and acts upon reality, etc., are particularly useful in anticipating how the patient will see and use activities and relationships, and give important clues to the selection of profitable activities.[6] It should also be noted that the clinical psychologist with his knowledge of projective techniques can make valid contributions to occupational therapy in the study and analysis of activities and their more specific integration with feelings and behavior. There is great need for research and further study of the "projective qualities" of activities, and collaboration of clinical psychology and occupational thepay would appreciably enhance these treatment concepts and techniques.

Of course meaningful exchange of information and effective utilization of occupational therapy as a psychotherapeutic measure is also in proportion to the skill and knowledge of the occupational therapist. Understanding interpersonal relationships, knowing thoroughly the psychologic properties of activities and being skillful in the use and interpretation of both of these will increase one's ability to state more specifically what can be achieved in occupational therapy and thus increase the potential for communication with other disciplines.

Occupational therapy, then, is used to modify or change behavior and feeling by providing activity situations through which the patient may learn to deal more constructively with his needs, drives and impulses as they relate to himself and others. For the individual who needs to obtain satisfactions at an infantile level the occupational therapist structures and manipulates situations which make possible actual or symbolic gratification of oral or anal needs, dependency needs, infantile aggression, destruction or control and infantile play. For example, some activities which may offer satisfaction for oral and anal needs are those involving eating, preparation of food, blow-

ing of musical instruments, singing, etcetera, and those which use excretory substitutes such as smearing or building with clay or paints, preparation of soil, collecting garbage or trash, and others. While dependency needs are more closely associated with relationships, they may also be met in activities which permit extensive guidance and assistance, those which can be learned by imitation, and those which make it possible for the patient to be waited on.[6]

Activities alone cannot accomplish therapeutic objectives with maximum benefit for the patient. Around the activities there must exist an appropriate and meaningful relationship. For instance, no matter what possibilities there are for dependency within an activity, if the therapist is unable to participate in this kind of relationship, little will be gained. However, since activities are the distinguishing mark of this discipline and since psychiatric literature is replete with material relevant to transference relationships, it seems reasonable to discuss more thoroughly the activity aspects with you at this time.[7]

In addition to dealing with infantile needs, occupational therapy as a psychotherapeutic measure may be used to assist the patient to find gratification for other needs and to work constructively with some of his other emotional problems. Sensory perception, motor coordination and social facility are problems basic to the schizophrenic, and he can be helped to deal with them in an occupational therapy program which provides gross muscle movement, rhythms, and activities having definite delineation of form. Then too, this is one of the few therapeutic approaches where a patient is bound to some extent to act upon his own ideas and observations and thereby test his perception through his work accomplishment as well as his personal relationships.

Ego growth and the development of the concept of the self is facilitated by the use of personalized activities which foster a sense of personal identity, provide narcissistic gratification, masculine or feminine identification, creative expression, and which assure successful completion on an individual basis or in relation to the group. Those patients for whom emotional needs create tensions and anxieties which interfere with therapeutic progress can be given opportunities to constructively express these. Overt hostility can be constructively channelled in hammering, sawing, beating a loom, etcetera; obsessive compulsive needs in organized, repetitious, mechanized performance; and in like manner activities can be planned which enable the patient to find acceptable means for expiating feelings of guilt, constructively utilizing competitiveness, and the need to excel or control.[6] "The clinic then affords a controlled situation in which the patient can express his unconscious emotional needs through activity. In the measure to which these needs can be constructively sublimated or directly expressed, the patient can find some relief. In addition to the direct relief from his behavior he is often then able to bring up material which can be discussed in psychotherapy.[4]"

The patient's participation in a carefully controlled and guided activity program can provide reassurance against many fears which beset him. Particularly fears of inadequacy and failure, of hostility and destruction from others, and, perhaps more important, fears of destruction from his own hostile impulses can be diminished through occupational therapy by controls set by other patients as well as by the physical qualities of the tools and material with which he is working. In addition there is perhaps more activity in occupational therapy even by the seclusive patient than in many other situations, and the patient is more constantly being made aware of the limits of acceptable activity as well as acceptable inactivity.

At this point it would be well to further consider the patient's need (particularly the schizophrenic) to develop a self concept and a sense of personal integrity and worth. Within a psychiatric hospital, and particularly in our state institutions, there should be increased awareness and appreciation of this need with all of its implications. It has already been stated that there are situations in occupational therapy which can provide narcissistic and other ego gratifications, and it is important in this respect to emphasize the value of a self care program. Opportunities for self care such as personal care of clothes, hair, cleanliness, use of cosmetics, etcetera, and encouragement of the patient in such activities are an essential part of any therapeutic program. The nursing service is usually responsible for programs of activities of daily living, but again no single procedure can be isolated from the total therapeutic approach. There exists a mutual responsibility, and occupational therapy can assist the nursing service in a self care program by structuring situations which encourage a carry-over of activities of daily living from the ward and provide the patient with an opportunity to practice these skills in relation to an activity program and the group.

Cooperation, exchange of ideas and information between occupational therapy and nursing extends beyond the self care program. The importance of the nurse as the center of patient interaction is well known and has recently been scientifically scrutinized and evaluated.[8] Treatment plans cannot be realized with maximum effectiveness without well integrated communication with the nursing service. This is readily understandable since the nurse spends more time

with the patient, tends to many of his personal needs, and in general may be considerad to function as the mother surrogate in a hospital setting. In this capacity then he has considerable influence on the patient's feeling and behavior and also can provide invaluable information about these to others. For the occupational therapist, day by day occurrences on the ward that may influence feelings and behavior in the clinic, how occupational therapy experiences are used in the informal ward situation, and how the patient seems to feel about these experiences are only a few samples of the kind of helpful data supplied by the nurse. On the other hand, information from the occupational therapist can give ward personnel an understanding of the patient's capacity to function in other situations.

With the changing role of the psychiatric nurse has come a more active participation and interaction between himself and his patients and an increased involvement with all aspects of the patients' living experience within the hospital. Out of this has developed ward activity programs supervised by nursing personnel. Occupational therapy has no patent on activity, and here again exists a situation where mutual support and cooperation offer infinite possibilities and new inroads in the treatment of our patients.

The emotional needs and problems of the patient are related to and influenced by other persons with whom he is in contact or to whom he relates. Group interaction and a sense of belonging are a necessary part of satisfactory living, and as such are not incidental to the occupational therapy situation. To encourage and facilitate group formation, to use group interaction to help the patient learn to live more effectively with others and to become a participating, contributing group member is another purpose of occupational therapy. As the patient is helped to deal more realistically with his needs and anxieties he is given an opportunity to explore new patterns of relationship and new techniques for solving the problems involved in more effective living with others. Through creative expression, symbolic use of projects or activities and the concomitant relationships, he can experience more meaningful methods of communication. Increased capacity to live with himself and others then leads to an expanded concept in living encouraged by occupational therapy procedures which increase his ability to recognize his own potential, encourage willingness to try it out, improve his skill in utilizing opportunity, and develop tolerance and understanding for the limitations of others and himself.

In the process of planning and carrying out a treatment program it is necessary to make valid observations and interpretations of the patient's behavior and to communicate these in a meaningful way to other members of the treatment team. The third function, then, of occupational therapy is to provide factual data for use in evaluations and diagnosis. This function may be viewed as having two aspects, one in which the clinical behavior of one patient is observed and reported, the other in which the product or specially structured situations are interpreted.

The first of these is perhaps the most familiar, and is concerned with evaluating and reporting significant responses in relationships and performance. The patient's use of color, his use of the project, his behavior toward authority, control, limit, his capacity to function within a reality situation, to follow instructions, patterns, etcetera, and his response to change or unfamiliar situations are only a small portion of the material available from occupational therapy which can be useful in verifying diagnosis or giving leads to new material for elaborating the psychodynamics within a patient.

The latter aspect of structuring special situations is most frequently associated with the use of creative art to uncover the unconscious. Other creative or structured activities have been less thoroughly studied from the point of view of diagnostics, but offer a wealth of investigative possibilities. Situations which allow for and evaluate the significance of a patient's free choice of a modality, performance in compulsive, aggressive, or regressive activities are again only a few of the possibilities for special investigation. There is a great need for further development in this area, and the psychologist's particular knowledge of projective techniques can assist the occupational therapist in more skillfully applying some of these techniques and concepts to activities and the situations around activities.

It should be mentioned here that diagnosis and treatment are not static affairs and that both run concurrently, and that both may reveal changes from time to time. In this light it is of significance and help to other members of the treatment team to know about changes which occur in occupational therapy in order that they may correlate them with changes in the psychological structure of the patient and in psychotherapy. Also the psychotherapist and others may be able to predict changes which are likely to occur within occupational therapy due to occurrences in these treatment areas. Of course the greater the communication, the greater will be the validation of observations and the usefulness of those made.[4]

As the patient begins to relate more comfortably with others and to work constructively on his problems, one can begin to think in terms of those steps beyond individual and small group

activities and relationships. This brings us to the fourth and final function of occupational therapy, namely, to assist the patient to undertake appropriate economic and social responsibility. Here the occupational therapist is concerned with the growth and development of community feelings, responsibility and participation. Utilizing those relationships, interests and efforts which have developed within the individual and small group, the occupational therapist assists the patient to find a place in the hospital community as a contributing member. A sense of belonging and mutual dependency between the individual and hospital community creates a wholesome respect for one's function and the function of others in a society, and prepares the patient for more constructive living outside the hospital.

A program in occupational therapy geared to the socio-economic needs of the patient is dependent in large measure upon satisfactory communication with social service. The psychiatric social worker contributes in many ways to patient treatment, sometimes as a group therapist, and always as one who can interpret and define the social and economic structure of the patient's living in relation to himself, his family and his community. A close working relationship between occupational therapy, social service, vocational counselling and others is essential in order that social, economic and vocational goals be realistically worked through with the patient and that he may be helped in bridging the gap between hospital and community living.

Rehabilitation of the psychiatric patient has lagged far behind similar efforts for the physically handicapped. This in certain measure may be due to a remaining doubt about the reversibility of mental illness, and perhaps the concept that since the individual has experienced no physical impairment he is able to return to his former job or continue those prevocational pursuits begun prior to illness. This latter concept is without regard to many of the emotional and social factors which may preclude a return to his pre-psychotic social or vocational adjustment. Whatever the reasons, we can agree that there exists a need to more clearly define our concepts in terms of meaningful rehabilitation for the psychiatric patient, and growth in this area is contingent upon an exchange of knowledge and understanding among all specialties in psychiatry.

Occupational therapy can serve as a testing laboratory for vocational skills is well as skills in relationships. In conjunction with the social worker and the vocational rehabilitation staff, opportunities can be provided for the refinement of skills, development of new skills, increased work tolerance and the development of profitable work habits. In addition to the occupational therapy clinic there exists within most hospitals realistic work situations where with appropriate guidance the patient can test his ability to function in relation to authority, to experiment in a give and take with co-workers, and try out his initiative and ability to discharge responsibility, as well as practice new occupational skills, or redevelop old ones.

In addition, occupational therapy provides opportunity for patients to have meaningful contacts with persons and groups in and from the community, by the use of volunteers, patient participation in outside organizations, community events, etc. The patient who can through skills and interest developed in horticulture participate as an active member in the local garden club or the patient whose stamp collection gains for him a place in this community group has begun to make a meaningful place for himself in his community.

There are many unexplored or only partially explored possibilities in the rehabilitation of the psychiatric patient.[9, 10] Some of these concern the function of occupational therapy in the day hospital, the sheltered workshop, the outpatient clinic, opportunities for the patient to gain some financial independence by marketing his products in the local community, and increased participation of the community in the hospital and of the patient in the community. Further development of these is not simply the function of the occupational therapist and social worker but is the shared responsibility of all of us. As treatment concepts grow, our responsibilities to our patients and our possibilities as therapists increase.

In closing I would like to quote from Fidler and Fidler[4] since it seems to sum up rather succintly what has been said.

"Occupational therapy is one of a number of approaches to psychiatric patients, and as such it must find its unique values in its relation to these other approaches and in acceptable means of communication with co-workers in other fields. Occupational therapy as a tool in this field has a special advantage in that it encompasses many possibilities that touch upon or overlap with some of the other special approaches to patients. This fact we believe affords a unique opportunity for occupational therapy to be of use in bringing together many specialized techniques and several areas in the development of patient treatment."

"The ability to let others know what one can do in his field and to let oneself know what others are doing may be used to promote a better understanding of patient treatment in general. For the further development of the profession

(*Continued on page* 35)

Eleanor Clark Slagle Lecture

THERAPIST INTO ADMINISTRATOR

Ten Inspiring Years

JUNE SOKOLOV, O.T.R.*

Editorial Note: The author, Miss June Sokolov, O.T.R., was chosen as the Eleanor Clark Slagle lecturer for our 1956 conference held in Minneapolis, Minnesota, 1956. The contents of this speech are so timely, the president of the American Occupational Therapy Association, Col. Ruth Robinson (AMSC), recommended an earlier publication date than the conference issue (July-August) which will carry the rest of the conference and institute speeches.

FOREWORD

To my peers and colleagues: You have seen fit to confer upon me a high award, the symbol of your respect and affection. I have been awed by this honor. I spent many hours deliberating a fitting subject for my discourse with you today and settled finally, not without some misgiving, upon the core of those philosophical beliefs which have been tempered during the past ten rewarding years of practice as a therapist and administrator. I am not an innovator; what I say here is far from new. I would only have you know that what I humbly share with you is representative of the deepest convictions I hold as a therapist, as an administrator, as a human being.

* * * *

THERAPIST INTO ADMINISTRATOR TEN TEMPERING YEARS

Some ten years ago the writer sat in a classroom attempting to assimilate and commit to indelible memory an impossible array of facts about the practice of occupational therapy. We were being prepared, in time-honored fashion, for the registration examination. From today's vantage point it is difficult to refrain from comparing that process with those rituals which accompany tribal customs. Certainly we resembled the uninitiated in all respects too closely for the comfort of either teachers or pupils.

Today, undeniably older if questionably better informed as a result of exposure to practical considerations, it is possible to recognize with some degree of equanimity that the makers of that first registration examination undoubtedly faced its trial run with something of the same apprehension that dogged the students who were soon to provide the test of its validity. However, ten years ago, such reasoning was at least temporarily denied to me. I could sense only considerable foreboding, reproach myself for my lack of faith in teachers and God and return to the fine print of the almighty text books there to search unremittingly for the meanings to puzzles which persisted in eluding me. What accounted for the sudden and bewildering synergistic action of a muscle which, up to a point, had behaved in calculable fashion as a prime mover? What nature of chemical compound was known to remove printer's ink from some spot where it had no official business? (And, wouldn't it be more efficacious in this instance to remove one's offending self from the premises as rapidly as possible?) What precautions did one observe with a sixty-five year old hemiplegic complicated by total aphasia, cardiac insufficiency and diabetes mellitus? Or, more to the point, what kind of occupational therapy program did one offer because, of course, there had to be one. This major faith, at least, in the unlimited scope and authority of one's chosen profession was unshakable.

So we pondered the technicalities of our profession, secure only in the one, irrefutable fact that all this was worthwhile and even possible because it would eventually permit us to realize our common aim of helping people to help themselves. What a rude surprise then, as we sat in that relatively peaceful classroom, to be singled out for the prediction that within three years' time I should have left the practice of occupational therapy for the province of administration. Impossible! Cold, forbidding word and world of topside decision and responsibility, devoid of all patient—nay, all human contact. How could one help but react with immediate rejection of such a fate. This could not happen to me. I wanted nothing to do with boards and committees, community action, finances, services and all the rigamarole of executive responsibility. I wanted to work with people. (Heaven forgive me and ascribe to the naivete of youth my repudiation of communities and their citizenry as something other than people. For among these were later to be found the generous affirmation of a personal faith.)

I have wondered since how many young people draw the same faulty inference. And, if they do, may our incorrect assumptions be traced to certain common administrative practices we meet as we move toward maturity and respon-

sibility, as well as to our human way of prejudicing a situation by seeing it in the narrow framework of imperfect knowledge rather than against the unlimited horizon we can flush with a little vision.

The predictions of our teacher were painfully accurate. Were I not so well acquainted with her discerning and judicious approach to life, I might well have suspected her of consulting a crystal ball or dabbling in extra-sensory perception. Almost three years to the day after taking up my duties as an occupational therapist, I found myself involved in administrative functions and by the time five additional years had elapsed, this had become the provocative and rewarding substance of my working existence.

I have no inclination here to propound the role of the administrator in scholarly or detailed fashion. The accepted texts devoted to this subject are adequate if not overwhelming. It shall be my pleasure (and yours, I hope) to dwell for a while on the art of administration which is essentially an art of working with people to encourage and assure those personal and group satisfactions which tend to result in affirmative, effective performance.

The great American myth of the push-button executive to the contrary, executives in social agencies, at any rate, must work chiefly with and through people. Some measure of their success may be noted in the degree to which this capacity for working through the medium of people bears fruit in the improved and even inspired performance of staff and the consequent greater good that accrues to those served. Obviously, we subscribe to a definition of success which pivots upon the quality of our human relationships. We are not primarily concerned with the size and scope of endeavors, the number and variety of personnel, the roster of services, the soaring annual budget, indicative as these may be of growth and development. Such attributes seem to be all too easily come by in an era of prosperity when rehabilitation of the ill and injured receives almost as much daily attention from the press as the political scene receives in an election year. The trick becomes how to avoid a mushrooming growth and hold to a realistic operation, a qualitative service, to moderate change that suits the circumstances and is not dictated by the artificial stimulus of a current trend.

What, then, are some of the values one perceives, infers and confirms in the process of working with and through people to achieve group goals.

If one tends to be inherently a "doer," a prime but difficult lesson to master and practice is the restraint and rechanneling of energies. The goal changes from personal performance to eliciting increased assumption of responsibility from others. For many people (therapists not excepted) doing comes easier than talking about it. In consequence, we may resort to showing or performing rather than sketching in a backdrop or opening a door, as it were. As has been said, a good teacher is one who leads the pupil to the threshold of his own mind and bids him enter. While more difficult to achieve, this is the procedure of choice and tends to insure more lasting satisfactions and greater gains in personal stature.

In any case, the pangs of relinquishing proof of personal competence are lessened at the earliest observation of staff satisfactions. And these staff satisfactions are the natural corollary of expanded horizons and the chance to come to grips with new and more challenging responsibilities. The first time one is suffused in a glow of pure pleasure because a staff member has ventured into new and untried territory to emerge either bruised and questioning or victorious and wiser, becomes the memorable date of a new romance with the art of administration. This is the moment when one feels the bite of conviction and knows where the greatest rewards will henceforth lie.

We hear frequently that young people of today do not crave responsibility—that they seek freedom from the burden of responsible choice and decision. As always, one does well to be chary of such generalizations. In those rare cases where the glove fits, we should perhaps be quicker to recognize true personality disturbances instead of chalking the response up as yet another "sign of the times." In our admittedly limited experience, an atmosphere in which the premium is placed on achieving personal satisfaction through exploring, investigating, making mistakes, finding out why, pooling group thinking and reaching out constantly to new accomplishment in the name of commonly cherished ideals, exerts the irresistible tug of a strong current and carries the worker with it magnetically. There is no substitute for the exercise of reason and self-trust and the reward thereof is constant. Given the basic aim of wanting to help people help themselves, human beings tend to gravitate toward those ways of life which promise to transform their intangible aims into realities. The administrator is on the scene to provide this opportunity, to set the stage for personal growth and to allow the accomplishment of group and agency objectives. How does he go about his role of catalyst?

One significant contribution he can make is to free the work atmosphere of irritating fears and tensions. We readily acknowledge that no one works successfully or happily in an atmosphere charged with constant anxiety or appre-

hension. Yet the evidences of such circumstances are legion. The writer has frequently been called on to define and analyze the reasons for ineffectual performance and poor standards of work, only to find that something akin to staff demoralization exists which freezes into immobility every healthy human and professional impulse. A change of leadership is contemplated, staff cutbacks are being considered, financial problems loom, a new order is in the making but no one has thought it necessary or fitting to discuss these crucial problems with the people intimately concerned. An undertow of panic results.

Let us illustrate the administrative function in such a situation. A new worker has been added to a well-integrated and functioning staff. This worker has left a secure position in the highly organized and orthodox field of education to seek new opportunities and horizons in the field of rehabilitation. He represents an unexplored aspect of service in the agency and brings with him a host of techniques, talents, beliefs, practices and prejudices which are new to the staff. He brings with him, also, a natural concern about the merits of his decision which was perhaps arrived at somewhat rapidly. It seemed like a good idea at the time. After a few days in a totally new environment and some encounters with unfamiliar practices, he's not so sure. During the orientation to the agency's services and the people behind them, it becomes fairly obvious that he is unable to listen, absorb, assimilate. He appears preoccupied, concerned with other things. He catches at details and misses concepts—sees the grain of sand but not the world mirrored therein. These symptoms readily communicate themselves to other staff members. Mental images are stored, calculations and reservations are made. It is time for administration to intervene in an attempt to rectify the situation before the staff begins to reflect an established group attitude which is apt to anchor these early responses. Informal conferences with the worker are aimed at clearing the air. These are not effective. The administrator takes another avenue. He consults with supervisory staff (department heads) about the problem. The possible and probable causes of the worker's reactions are weighed and considered and a potentially influential group attitude is forged. The staff concludes that the new worker deserves all the help they can muster to convert his energies and will to the job at hand. They agree that his unease is, undoubtedly, temporary. To a man, they go forth determined to offer extra assistance, encouragement and support to help channel responses and criticisms to appropriate sources for consideration. Within a very brief period results may be measured in the new staff member's relaxed manner, receptiveness to suggestion and participation in group thinking and planning. After a month or two, he is working with obvious satisfaction and making a substantial contribution to the agency's objectives in terms of his personal endowment. A group of people who have worked toward and achieved a common set of goals have succeeded in communicating their good-will, enthusiasm and positive experience to another human being. The link is forged into the chain. Administration has helped to refocus group energies on meeting client needs. Similar examples abound. Every department, every agency is the scene of innumerable tensions, group and personal. They are a part of the fabric of existence and no more to be frowned upon than the rind we discard with the eating of an orange. But they must be recognized and evaluated for potential damage. Sensitivity to impressions, recognition of a disturbed environment, proper timing, analysis of the problem and bringing to bear upon it the powerful antidote of group acceptance are implicit in the administrative function.

The cultivation of impressions or intuitions is worth a moment's digression. While we may not rely indiscriminately upon a single impression, many such perceptions constitute the genesis of all ideas, the basis for achievement. Henry James has summed this up exquisitely in *The Art of Fiction and Other Essays.*[1] He discusses the business of writing from experience and says, "Experience is never complete; it is an immense sensibility, a kind of huge spiderweb of the finest silken threads suspended in the chamber of consciousness and catching every air-borne particle in its tissue. It is the very atmosphere of the mind; and when the mind is imaginative—much more when it happens to be that of a man of genius—it takes to itself the faintest hints of life, it converts the very pulses of the air into revelations. The power to guess the unseen from the seen, to trace the implications of things, to judge the whole piece by the pattern, the condition of feeling life in general so completely that you are well on your way to knowing any particular corner of it—this cluster of gifts may almost be said to constitute experience . . . If experience consists of impressions, it may be said that impressions are experience, just as they are the very air we breathe . . ." And he goes on to admonish "Try to be one of the people on whom nothing is lost."[2]

One of the major fears which confront occupational therapists as administrators is an expressed or implied fear about the value of occupational therapy itself. Like most fears, this one if suspected must be taken out and viewed in that strong daylight which does so much to dispel shadows and reduce problems to size. Con-

versely, when it has been examined and analyzed for the benefit of all concerned, doubt and distrust should be dispersed by the active, intensive and changing practice of our profession. The Overstreets speak convincingly of learning to call an episode finished when it is over with, and label this "the art of rescuing the present and the future from the tyranny of the past."[2] If occupational therapists persist in some of the breast-beating and loud self-recrimination which have attended us too regularly in the past eight to ten years, we cannot expect the world to look upon us with either respect or trust. No one denies that we must examine the reasons which invest our practices. We might, however, do well to remember that T. V. Smith, the eminent philosopher, upon his retirement thanked God publicly for the right of old age to "withstand all easy commitment." "All my life," says Mr. Smith, "I have been abashed at having to decide things in the name of reason for which there were no adequate reasons. I know there were not, because equally reasonable men are always deciding such things differently. And the more important the issues, the more differently they get decided. . . . Indeed, I myself incline to the view . . . that there are never adequate reasons for doing anything."[3]

All of us have heard and perhaps uttered the cry of frailty: occupational therapy will not live to see another decade if it is not perfected as a science; if we do not recruit more therapists; if we do not settle the problem of unregistered personnel. All these qualifications are dependent on which crisis looms largest in the group addressing itself to the problem of our future. These are problems we must deal with, yes, but they do not constitute a final threat to the life and vitality of occupational therapy any more than the rising cancer rate threatens the life or continuous practice of medicine or the hazards of the road threaten the use of the automobile. The seriously debilitating factor is our own lack of faith and conviction about what occupational therapy has to offer the patient. Nothing will erase this basic fault except the cultivation and practice of a genuine belief and its substantiation in the daily revelation of efficacy.

A good deal of our discomfort and uneasiness may stem from the fact that we, along with other disciplines, are living through an attempt at conversion to a more exact science. This is a painful process at best and can be devastating to a profession burdened with amorphous beginnings which lend themselves all too easily, in the hands of the unselective, to branding occupational therapists with currently unacceptable labels, such as "do-gooders."

Daily we are impressed with the revival of interest in religion, the revanescence of handcrafts, the renewed emphasis on a liberal arts education. All about us are signs of the swing of the pendulum from crass materialism to a renewed acknowledgment of man's continuing need for human kindness and compassion, for individual creative effort. What could be more reassuring to people engaged in the practice of healing through doing?

With an apology to our psychiatric colleagues who, I suspect, have always known and held to this conviction, it behooves us to emphasize and underscore the significance of effective human relationships implicit in the practice of occupational therapy whether we are talking to a physiatrist or a psychiatrist. Regardless of our tools, it is primarily by virtue of our interest, enthusiasm and concern that we shall bridge the chasm of illness to draw the patient back into the mainstream of active participation which signifies the return to life and hope.

This is in no sense a repudiation of the effort to improve our practices, sharpen our professional tools, better our methods of work. It is dictated by a deep-seated belief that the medium we use is always secondary to the motives and drives which direct our actions.

The administrator becomes an important avenue for the unequivocal voicing of such sentiments since his attitudes and beliefs will unfailingly be sensed and transmitted to the staff. His is the job, then, of conditioning the atmosphere so that unspoken fears may be voiced, group attitudes reshaped and fused, healing action taken to correct the profound debilitation caused by irritating doubt.

Patient evaluation sessions, used as a teaching device, may provide a useful vehicle for crystallizing group attitudes about occupational therapy. It is more than a passing impression that, given the opportunity to comment on the function of occupational therapy, the therapist too often remains passive and silent only to fester later under an impossible assignment doled out by the attending physician. Administration has a responsibility for overcoming such deadlocks. A leading question directed to the physician, the therapist or both, may instigate the conversational give and take that is essential to the forging of individual ideas, the art of selling them to others, the grace of retreating with good countenance and heart when fairly defeated and the satisfaction of having actively contributed to decisions about the purpose and function of one's own metier. The old, if somewhat impertinent, remark about "put up or shut up" has its merits. applied to this situation. Staff members must learn to charge, parry, thrust, defend or retreat in the intellectual arena much as they have pre-

viously learned the rules of the game in the sports arena.

Clearing the air of basic fears about the value of occupational therapy is an on-going process. Self-recrimination should give way to the more purposeful activity of meeting problems as they arise for these are the stuff of life and ours the incomparable privilege of rising to their eternal challenge.

The art of administration supposes, also, acknowledgement and cultivation of an atmosphere in which a premium is placed on the making of courageous errors. We do well to recall often the sense of peace and freedom to be found in reviewing our identification with the family of man, that curious groper after knowledge, that colossal maker of mistakes. How comforting to know that one is entitled to try and fail, that it is upon this shifting foundation that all human advances are achieved. From "The Mind Goes Forth," we take heart in the following quotation: "The deeply civil person knows life as imperfect, flawed, limited, self-contradictory; as unfinished; often immature, raw on the edges, unfulfilled; but as remarkable in fact and possibility and as structured for growth. With all these aspects the truly civil person feels at home."[2]

Administration generally has responsibility for inaugurating teaching programs. The example set by first-lass hospitals leaves little doubt that clinical teaching enriches and improves services rendered to the client. The new knowledge, the fresh perspective, the spirit of inquiry the student brings with him illuminate the scene and stimulate the staff to their best creative effort. To the degree that all experience is grist to the human mill, we may assume the student also profits. In attempting to qualify the returns to the student over a period of years, certain basic ingredients of a teaching program parade before us for review.

Young people often come to us hemmed in by the safe margins of the knowledge they have assimilated well. They will not readily push these margins out unless we commend the pioneering spirit and, indeed, breast the frontiers ourselves. This should not be promptly equated in the listener's mind with study and research, applicable though they be. It is much more an attitude, a state of mind which invests our every action, from shifting a schedule to tossing out a traditional method for some new system. It is, we believe, a refreshing jolt for the new student who arrives on the scene primed for performance (with the mental image of the rating scale never far away) to be assured that he will be rewarded for imagination and invention, that his supervisor will cherish trial and error rather than past performance according to text book specifications.

Gradually, we have had the temerity to question the fine line drawn between the status and responsibility accorded the student and the therapist. It seems to us that this is a chimera which cannot be perpetuated if we hope to give to student and patient that sense of security and authority which are prerequisite to a positive relationship. In seeking to create for the student a level somewhat below that of staff prestige, yet to demand from him those things expected of a staff member (with the possible exception of ultimate responsibility to administration), we seem to be pursuing an unrealistic, if not unattainable objective. In good government we underwrite responsibility with authority. The student in training is anywhere from one to nine months short of his first job. Overnight, he will be expected to drop the pose of subservience and assume the mantle of adulthood. Since few of us are quick-change artists when it comes to personal development, the outcome of such a system will generally be an additional year of growing into responsible performance. Yet the current situation demands prompt assumption of leadership and mature judgment from the new therapist. This is often deplored but I suspect it is something we might cease to deprecate. In many of the established giant businesses of today this golden option for personal responsibility has been severely curtailed. Thousands of young clerks and typists seem never to move beyond the immediate assigned task, be it filing the card meticulously under "C" or typing the letter neatly and accurately. The card may bear information of keen significance to the boss and the letter may read like gibberish but there will too seldom be an attempt to check on the information or to read the letter for sense. This is not necessarily the sign of a dull mind but rather of a dependent one which has been denied the God-given opportunity of thinking for itself, of questioning, of investigating even at the risk of appearing foolish.

To a degree our schools perpetuate this state of dependency. We still persist in spoon-feeding substance to students, examining them regularly and all but lifting them through the business of learning with methods and devices as adroit as they are stultifying. We forget or overlook the fact that education in its deepest sense is "life-long discipline of the individual by himself."[4] We assume self-discipline will set in, like grey hair, after the student is on the job.

If the therapist-administrator seeks to engender a dynamic and rewarding teaching program he will do well to examine this dichotomy and establish the student as a full-grown person of

whom is expected the creative effort, natural error, renewed curiosity and growing capacity for responsibility which we associate, whether rightly or wrongly, with the finished therapist. In place of the smothering pat of authoritative approval, we may substitute the listening ear—the sounding board against which the student may try the "ping" of his ideas. While this may play some havoc with established efficiency, it will assuredly contribute to personal and professional growth.

We are reminded of an episode which may illumine these abstractions. A student was treating an emotionally labile hemiplegic woman of middle age. The physician in charge was carried away with the importance of self-care for this patient and somewhat arbitrarily emphasized this in his prescription to the exclusion of other activities. In the manner of many busy doctors, he had found little time to examine the background of the case which indicated a long career of drudgery interrupted for the first time in many years by the respite of illness. The student was vaguely aware of this implicit contradiction but failed (in traditional fashion) to verbalize it to the doctor. Instead, she proceeded to carry out the orders to the letter. The patient broke down and sobbed uncontrollably on the day she was first able to master her shoelaces alone. The student, shocked, discussed the situation with a therapist who, neither condemning nor approving, helped the student to voice her desire to try a less orthodox approach. Utilizing a spark of interest the patient had revealed for drawing and painting as a stimulus to other activities, the student encountered some success. She was asked to present the results to the physician, who, in the face of the evidence and the student's newfound assurance, was moved to adjust his recommendations. Much was learned; a small world was conquered. Had the therapist, at the outset, issued warnings about deviating from the prescription, we might have succeeded solely in perpetuating a blind and mulish adherence to rule.

Physicians who enjoy the practice of medicine as art and science, rather than the artificial prerogatives bestowed by overawed humanity, tell us that they are neither qualified nor interested in planning discrete occupational therapy programs. They alone can and will set the guidelines for us, indicating the pitfalls and dangers inherent in treatment. We must heed this advice and also the ring of inner conviction which tells us that we alone can create, devise and adjust the program of therapeutic work which is our contribution to the healing process.

The cult of objectivity in human relationships has occasioned a good deal of fanfare in our teaching and clinical training settings. Random observations in our own field and allied situations moved us to examine this precept and to cast our vote with those who believe it is neither possible nor desirable to establish antiseptic relationships with people, to divest our relationships of some degree of emotionality. Undoubtedly some of the existing confusion we experience here rests upon problems of semantics. The word "emotional" is often viewed in the narrow sense of uncontained feeling. It appears to the writer that what we bring to patient or staff relationships rests largely upon our ability to manifest a warm interest in individuals as people. An axiom of our profession is the importance of our approach to people. Just what do we mean by this? Is it a kind of come-on that we hold out as bait until the fish is hooked, then to withdraw rapidly into our shell of cool aloofness? Or does it mean that we are able to convey to people at all moments of our relationship that they are important and valuable to us, that we have an investment in their future, that we care considerably what happens to them. If we accept the evidence that what we do and say often influences even momentary or fleeting relationships, how much more obvious is this potential in daily association? As members of the genus homo sapiens we all move in a constant search for understanding. As human beings we are not constituted to live together without involvement. We have learned that events across the span of oceans and continents affect us, that we are in more than an abstract sense our brothers' keepers. This is no less true of our more intimate associations with patients and colleagues. To the degree that these feelings are neither unrecognized nor unmanageable, they are, we submit, the most powerful tool we have for evoking response and encouraging movement forward. And, if we should err, let us remember that we were not meant to be omnipotent. People will forgive us the errors made in the name of earnest belief more readily than the achievements which result from calculated planning. We should differentiate this kind of response to others from the casual benevolence that rests upon familiarity with the size and fortunes of Joe Doake's family as the base of association. The kind of interest we propose as a part of the administrative armamentarium is an enlightened concern with personal growth and achievement.

In this role of helping people to achieve commonly held objectives, nothing is more rewarding than our deepening awareness of human strength and frailty. One learns to hold aloft the ideal, to expect from people the most and the best of which they are capable yet to respect human frailty and hence to treasure the least of the offer-

ings. As the staff family grows from a few people who have learned to harmonize "exceeding sweet" to a whole chorus which is more apt to give out with a sour note from time to time, there is, for the administrator, the endless fascination of reading an increasingly complex score. The bass are the conservative element, holding the line, providing the foundation; the tenors are the mercurial element, given to temperamental sallies and sudden bursts of melody; the contraltos are the mediators creating a blending of voices; the sopranos carry the design ever onward. All have their inalienable place and the whole is the less for any loss or absence.

The importance of expecting the best from people is illustrated by the remarks of a famous dancer who, as she exhorted young and very green converts to attempt greater feats, pointed out that few of us know even the inside limits of our endurance, nor do we take the time or trouble to find this out except when life itself calls the turn. I remember that we students had been complaining that we could not run any longer. The artist dared us to test this statement. She suggested that we run until we dropped of breathlessness or a stitch-in-the-side. Some of us took the dare and learned, in the process, an illuminating lesson about the depth of our endurance and physical powers. This can be translated into mental efforts. People may gripe and complain about being stimulated and provoked to new and greater efforts but, in our humble opinion, they respond to challenge as the hound to the hare. This is no more nor less than a reflection of man's eternal striving after perfection. Attainment may, indeed must, in many instances fall far short of the goal. This is secondary. It is the reaching that counts; not the thing we grasp. The sense of joy and accomplishment, of participation, are to be found on the march. The goal, achieved, has already altered and is elusively beyond us again.

Another lesson to be mastered in this complex and provocative business of working with people is the sharpening and refinement of the sense of timing. How easily one loses the golden opportunity to communicate an idea or advance a plan when the time is either too soon or too late. We might speculate lengthily that timing is the essence of success in all things great and small. Certainly it has a place in successful administration. The atmosphere of a staff or board meeting, the readiness of people for a concept or plan, the degree of skepticism, the point at which this turns to argument, the introduction of personal motives and consequent loss of focus on the objective, all these are as significant to the development of the administrative sense as the scent of smoke on the air is to a present danger for animals of the forest. Reactions like these are not to be overlooked in the ardor of one's own beliefs. Personal conviction and zeal spice an offering but they must be preserved within the framework of group readiness much as a treble phrase plays a counterpoint against a holding base.

While the sense of timing can be enhanced with experience, it has in common with all true things an intuitive basis. We say of the gifted politician that he can sense the mood or will of the people, and uses this to introduce advanced ideas and doctrines. This is equally applicable to the administrator who, seeking to inaugurate a new policy with staff or board, must consider group structure, mood and will. Long ago Shakespeare immortalized this idea when he said, "There is a tide in the affairs of men which, taken at flood, leads on to fortune . . ."

By way of example, a staff may resist the introduction of a timesaving procedure for the exchange of routine information. They are unmoved by the suggestion that such measures will reduce the burden of frustration upon individuals. The matter is discussed and, wisely, tabled for the present. Soon the moment for which our administrator has been waiting arrives. Several staff members register complaints about the lag in communication. While this irritation is prominent the staff is convened to hear an expression of the problem by its own members. Together the group seeks an answer and happens, magically, upon the plan originally proposed by administration. The time is right; the goal is realized. Astute members of the group recognize some semblance of coincidence, to others this is not yet revealed. This is unimportant. With faithful practice, everyone is eventually in on the secret and common obstacles may be hurdled with the speed and co-ordination that endow the polished athlete.

The tempering years have sustained our conviction that the goal of harmonious group performance, per se, is a false idol. One insurgent and gifted human being is worth twenty robots who have been chastened into the uncomplaining performance of assigned tasks. New ideas, new people, new projects may threaten to disrupt equilibrium, upset patterns, create temporary dissensions. Do we decide for or against their injection into our midst?

Some of our social scientists have been preaching that "the whole is greater than its parts, that the system has a wisdom beyond the reach of ordinary mortals." William H. Whyte, Jr., writes tellingly of this quandary in *Is Anybody Listening.*[5] Says Mr. Whyte, "The individual can be greater than the group and his lone imagination

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THE FUNCTION AND VALUE OF A PRE-VOCATIONAL UNIT IN A REHABILITATION CENTER*

HENRY REDKEY**

The great and increasing interest in pre-vocational programs in rehabilitation centers is very heartening. The idea of pre-vocational activities in rehabilitation is not new, but since 1954 it has received far more attention than ever before. This has resulted from two deep currents in the development of rehabilitation generally, which merged and found expression in the Federal legislation of 1954.

The first of these currents was the recognition that rehabilitation, particularly of the severely disabled, requires teamwork among many medical and related specialties if it is to be successful. With this recognition is a corollary of equal importance. No longer do we dare equate one discipline with the totality of services demanded in rehabilitation. Indispensable as it is, medicine alone cannot rehabilitate. Nor can occupational therapy, vocational counseling, vocational training, psychology or social service.

The interdependence of disciplines lies at the heart of the concept of a comprehensive rehabilitation center. In a center, areas reserved to particular disciplines tend to be reduced. More disciplines are added, and increasingly they all work together. As a result, each of the disciplines is practiced somewhat differently in a comprehensive center than is the case in other situations. This is particularly true of occupational therapy, which in a hospital or non-comprehensive center may perforce have to furnish whatever vocational or pre-vocational emphasis is given. But, in a comprehensive center, services in the vocational area are furnished in a division of vocational services which is staffed with a variety of specialists.

The second deep current lies in public acceptance of rehabilitation and in the demand that service be made available to larger numbers of disabled persons, many of whom are severely disabled. The President's goal of increasing the number of persons rehabilitated from 60,000 to 200,000 per year is a clear expression of that demand. In an age of specialization and scientific accomplishment, the public will not be patient with a rehabilitation program that does not attempt solution of the problems of the most severely disabled.

These two currents merged to bring forth Federal legislation in 1954 which called not only for a greatly expanded State-Federal vocational rehabilitation program, but also for the creation of comprehensive rehabilitation facilities where teamwork would solve the problems of those whose disabilities are most severe. Significantly, these laws also provided for research, demonstration and training. How this legislation is implemented will greatly affect our thinking about program in general and about rehabilitation centers in particular, and will necessarily influence the role of each discipline involved.[1]

In these circumstances, it is encouraging that occupational therapy should actively re-examine its function, its training programs, and its relation to other specialties in rehabilitation.

Of interest, I am sure, is the fact that as of July 1, construction will begin on 42 comprehensive rehabilitation centers, involving the expenditure of from 18 to 20 million dollars in private, State and Federal funds. With a few exceptions, all of these will have pre-vocational units.

Never before has there been such a strong effort in rehabilitation centers to deal effectively with the vocational problems bound up in severe disability.

Why, one may ask, is there so much emphasis on pre-vocational programs? The answers are simple. A center must deal with the rehabilitation problems of patients whose disabilities are so involved and severe that in the past they have been passed over as impossible of rehabilitation. To meet the problems we have turned to the idea of comprehensive services, highly specialized and carefully integrated, in a rehabilitation center. In such an integrated program, it is critically important to recognize and deal with all phases of the problems presented, be they vocational, medical, psychological or social. For each client we must develop a plan which has a reasonable chance of success with that individual. They will not, by any means, be easy. But, if our energies are constantly directed at that result, if we can re-think our relationships and our methods, it should be possible for a so-

*Address given at the regional institute, "Prevocational Techniques to Media," June 12-15, 1956, Richmond, Virginia, which was sponsored by the American Occupational Therapy Association and made possible by a grant from the Office of Vocational Rehabilitation, United States Department of Health, Education and Welfare.

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ciety which has harnessed the atom, to make real living possible for those whom disability has hit the hardest.

This effort calls for a program that is balanced. Vocational services must be as good as the medical, and the psychological and social as good as either. As Wilma West has well said of rehabilitation, "It was one-sided at first. It had to mature and develop a balanced view and approach."[2] That maturation is precisely what is happening in comprehensive rehabilitation centers today. Addition of well-organized and directed pre-vocational activities in the center is a very important part of that development. One of the reasons the concept of comprehensive rehabilitation centers has grown is that too many existing centers concentrated almost exclusively on medical aspects of rehabilitation, and a few others sought to solve all problems with a vocational approach. A typical patient's problems fall in all four areas and any balanced approach must deal with his problems as we find them, not as we might wish to have them presented.

We believe that as vocational rehabilitation accepts more and more cases with severe disability, we shall find that vocational adjustment will be more difficult to attain. Traditionally, vocational rehabilitation has functioned through counselors who arranged or procured services of different kinds which the client needed. The counselor achieves integration through his counseling and planning function. While this has worked well for a large proportion of those who are moderately disabled, it is not adequate for those whose rehabilitation problems are involved and difficult, and for whom an evaluation requires an extensive work-up by a variety of specialists.

We, in vocational rehabilitation, shall need to send more and more difficult cases to rehabilitation centers, but we shall also need to apply the test of ultimate employability which is basic to our program. It becomes imperative, therefore, that centers furnish the most definite pre-vocational work-up that is possible. This is an important reason why pre-vocational activities have received so much emphasis.

Vocational evaluation is even more important in rehabilitating the mental cases, and this is a rehabilitation problem that is bigger in numbers than any we have yet dealt with. Dr. Howard Rusk quotes an estimate of nine million persons in the United States who suffer from some form of mental illness, one person in every seventeen. He reports that "studies in Great Britain and in this country have shown that from ten to fifteen per cent of the patients with emotional illness who are being discharged from mental hospitals need work adjustment experiences, pre-vocational training, and the other services we call rehabilitation."[3] Vocational rehabilitation must meet that need on an ever-increasing scale and the pre-vocational program in centers should be an important means of doing it.

The need for pre-vocational programs, therefore, springs from the concept of integrated, comprehensive services; from the neglect of vocational problems by rehabilitation centers in the past, and from predictable needs for pre-vocational evaluation on the part of the severely handicapped whom vocational rehabilitation must serve in increasing numbers to achieve the goal set by the President and the Congress.

In any program that expands as rapidly as the pre-vocational one is now doing, it is natural that there should be some confusion about its proper place in the administration and functional organization of rehabilitation centers. In such cases, the simplest approach is often the best; the easiest way to visualize the administrative organization of a comprehensive center is to think of four services or divisions in it. Ranging from left to right, these major divisions would be medical, psychological, social and vocational.

In the medical area would be found a number of services such as physical therapy, occupational therapy, speech therapy, medical consultation, medical supervision and medical evaluation. Under the psychological division would be found evaluation, and some centers would include personal counseling here also. Under the social division would be found social evaluation, social case work, and possibly recreation and social group work. Under the vocational division, as in the medical division, would be a long list of services. These would include vocational evaluation, vocational counseling, pre-vocational activities and possibly sheltered employment and placement.

Thus, organizationally, the pre-vocational unit is properly a subdivision of the vocational division. The chief of the vocational division is responsible for the proper functioning of all vocational services, including the pre-vocational unit, just as the medical director is directly responsible for all functions in the medical division. It is important to note here that we are speaking of the administrative organization of a comprehensive center. There are also important functional relationships, particularly those involving the physician which will be discussed later. Also, we have not discussed here who should exercise over-all direction of the center. But, whoever he is, the chief of each of the four divisions, medical, psychological, social and vocational, would report directly to him.

This, I believe, clearly sets forth the administrative structure of a comprehensive center, and

shows where the pre-vocational unit fits and how it relates to other services in the center. In some of the plans we have seen for new centers, the pre-vocational unit has sometimes been confused with vocational counseling or with the whole vocational service; or it has been set up under the medical or psychological service. It should be one, but only one of several important activities in the general vocational division.

NATURE OF THE PRE-VOCATIONAL UNIT

To achieve its purpose, the pre-vocational unit should bring the world of work to the center. It should develop an area where actual working conditions can be realistically simulated. Whereas, medical services in a center are necessarily a continuation and a tapering off of services begun in the hospital, vocational services, particularly the pre-vocational unit, represent a first beginning of what is to come later in a vocational training school or in actual employment.

The atmosphere is different. It should emphasize to the patient that his being there, even for a portion of the day, marks for him a long forward step toward his goal of employment. The atmosphere should reflect this—being more like a factory than a clinic. There should be no white coats or uniforms, and there should be noise and dust and dirt, in moderation. For patients who have never worked, this may be their very first experience with anything remotely resembling the world of work; this is an opportunity to be exploited. For patients who have worked before, the change from a therapeutic setting, however helpful it may have been, the noise and work will be most welcome; it is a sure sign that progress is being made. Just as a patient loathes being waited upon in bed after he is able to do something for himself, so the person in a rehabilitation center relishes leaving the helpful doctor, nurse, and therapist for a return to work. For work is often the test of all that has gone before: work means self-respect, freedom, and the prospect of living again as he pleases.

Pre-vocational activities involve a sampling of actual jobs upon which the patient is tested for both qualitative and quantitative performance. His achievements are matched against the criteria the employer actually uses. Most of the cases in the pre-vocational unit will be difficult. More job possibilities for the patient will be eliminated from consideration than will be found suitable. But, there is at least a narrow range of jobs that can be learned or in which the patient can be immediately placed. In these jobs lie the largest hope the patient has. The testing, therefore, in suitable job possibilities must be carefully and painstakingly done by good personnel with good equipment in ample space. In their way, I should like to see pre-vocational units as well equipped and as efficiently managed as operating rooms. For, believe me, the results are almost as important.

I should like to emphasize the importance of the advisory committee which we have recommended for every pre-vocational unit. In undertaking to bring a realistic sampling of industry into a rehabilitation center, we are going beyond the usual field of knowledge of the doctors, therapists, and even of the rehabilitation counselors and industrial arts people found on a rehabilitation center team. We shall be offering services with which our patients may in some instances be more familiar than we. They may be the first to spot our shortcomings. If this effort is to meet with success, it must be intensely practical and I know of no better way to make it so than to take into partnership people from industry, placement and apprenticeship training. We should let them advise and guide us. Without this I fear we who are specialists in other fields may end up with something called by a good name but lacking in real value in the rehabilitation of those who look to us for help with the most critical problem they have ever encountered—their rehabilitation.

As we progress with the development of pre-vocational units, we shall need to develop criteria that are as objective as possible. Mere aimless try-outs will have little value to the client or his vocational counselor. One center, the Institute for the Crippled and Disabled, has evolved a rating scale on a series of job samples which ranges from zero to ten on manual dexterity, zero to ten on vocational equipment and basic tool manipulation, and contains eleven qualitative criteria based on production rates actually demanded in industry.

RELATIONSHIP OF PRE-VOCATIONAL SUPERVISOR WITH OTHER STAFF MEMBERS

Relationships of the pre-vocational supervisor with other staff in the center is clearly set forth in the bulletin, "The Pre-vocational Unit in a Rehabilitation Center."[4] In general, the pre-vocational supervisor brings to the group much practical experience from industry but, like all other staff, he contributes to the whole. He does not make the total vocational evaluation, only part of it. Neither does the vocational staff speak for the whole center. The pre-vocational supervisor is and should be a member of the team contributing his special knowledge, but constantly learning from other staff. It is therefore not necessary that he be a doctor, for the team has a physician. Neither need he be an occupational therapist, for there will always be an

occupational therapy unit in a comprehensive rehabilitation center with which he can work. He will need to appreciate medical, psychological and social factors as they may bear upon the people he serves, but he need not be expert in them. That is why we must have a team in the first place.

In referring to administrative organization earlier, I said that there were important functional relationships that cannot be detected on the organizational chart. There are many of these, but the relationship of the physician to the pre-vocational unit is perhaps the best example. In the medical service, the physician prescribes and initiates services which therapists carry out under his supervision. In the vocational service, however, the vocational director initiates service and supervises it, but he does not prescribe. However, in any given case in the vocational service, medical factors remain important, often of critical importance. Vocational or any other personnel ignore them at their own and the patient's peril.

While the doctor does not prescribe or supervise vocational services, he does furnish much of the basic data which responsible vocational personnel will follow. In addition, as a member of the team making the overall plans for the individual, the physician can, does, and should set forth limits within which any of the activities may be undertaken with safety for the patient. He is regularly informed of what happens to the patient in the vocational service, and should immediately intervene if such intervention is necessary to protect the patient's health. He should visit the pre-vocational unit and he should be the trusted advisor of the pre-vocational supervisor. This, I think, is medical supervision in the practical sense. It is different from administrative supervision. I am confident no doctor and no pre-vocational supervisor would want it otherwise.

Under P.L. 482, the Medical Facilities Survey and Construction Act of 1954, it is expected that approval will be given for the construction of 42 centers during this fiscal year. Some of these are completely new projects, others provide for expansion of space, equipment and personnel in existing centers. We must think now about how to staff them in the next 12 to 18 months. Three types of personnel would appear to have suitable basic training for this work: industrial arts teachers, occupational therapists and rehabilitation counselors. While the basic training of each is relevant, each would require supplemental training and orientation to this particular activity. Each would have difficulty leaving behind him much of his experience in order to work in this new situation.

The industrial arts person must leave behind him his bent for vocational training. He must learn about handicapped people. Whereas the teacher works largely on his own, the pre-vocational supervisor works closely with a highly specialized team. He must certainly be the type of individual who is interested in experimental testing and be more adaptable than most. His knowledge of trades and industry and his ability to work with an advisory committee from industry will be strong points, but like every other center staff member, he must have that indispensable "feel for people" and a healthy respect for the specialized knowledge of others based upon real security stemming from confidence in his own knowledge and his ability to contribute.

The occupational therapist who heads a pre-vocational unit will likewise need special orientation. He will now be leaving the medical service behind him; he will no longer have a prescription for all he does. The white uniform will be missing. He will find himself interpreting industry to his medical, psychological and social colleagues, and he may often find it necessary to disagree with them. His work with the advisory committee from industry will be something new and if he has not actually worked in industry at some time in the past, he may not be quickly accepted as competent in this area. He has the advantage of extensive knowledge of the medical portions of rehabilitation.

The vocational rehabilitation counselor, accustomed to verbal counseling, may find the pressing need for more and more objective data and precise measurements somewhat frustrating. From outdoor work to the confines of a laboratory is a long step. Close working relationships day by day with a team containing many highly trained specialists is quite different from just using the findings which are the end result of such teamwork. His formal training may be substantially less than that of other team members, and the harsh realities of jurisdictional rivalries and rigidities may give him a jolt. He may have the highly desirable actual experience in industry and he should find work with an advisory committee more familiar than some other portions of the job. He has the advantage of being quite familiar with the steps in rehabilitation which must follow treatment in a rehabilitation center.

For the country as a whole, there is the difficult problem of shortages of personnel in all categories. In the Office of Defense Mobilization report,[5] we find that there are 3,900 practicing occupational therapists and that there is a need for 10,500, a shortage of 6,600.

The Office of Vocational Rehabilitation reports that about 1,200 people are engaged in vocational rehabilitation counseling and that there is

a projected need of 4,000 in the vocational rehabilitation program alone.

The United States Office of Education has informed us that in industrial arts, we are at least dealing with larger numbers and consequently might find more individuals interested in becoming pre-vocational supervisors. There are 30,000 teachers trained in industrial arts. Two hundred colleges offer training programs in this field. About 2,500 persons are graduated from these schools each year. About half of them go into teaching; most of the remainder go into industry.

It would appear that the best opportunity for recruiting the needed pre-vocational personnel lies in the field of industrial arts.

CONCLUSION

In the increased emphasis on the vocational components in center programs, we are seeing, I believe, a basic development in rehabilitation centers. The expansion of vocational services is far-reaching in terms of volume, of relationship to other disciplines represented in a center, and most important of all, in enabling centers more effectively to meet the needs of the severely disabled. This is all the more significant in the light of the fact that all rehabilitation agencies, public and private, must shortly come to grips with the rehabilitation problems of the emotionally handicapped. As we become immersed in these tougher problems, I believe we shall find that the addition of well-organized and direct pre-vocational units are essential to comprehensive rehabilitation center programs. We shall then wonder why we waited so long to develop them. This development brings new challenges to occupational therapy, new relationships, and new opportunities, and the spirit in which you are re-examining your functions bodes well for the contribution you may make to it.

REFERENCES

1. P.L. 482, 83rd Congress; P.L. 565, 83rd Congress.
2. *Proceedings of the Occupational Therapy Institute*, June, 1955, p. 74.
3. *Proceedings of the Occupational Therapy Institute*, June, 1955, p. 10.
4. *The Pre-Vocational Unit in a Rehabilitation Center*, Office of Vocational Rehabilitation.
5. *Mobilization and Health Manpower*, ODM, 1956, p. 17 and 41.

The ninth western international conference of occupational and physical therapists will be held in Vancouver, B. C., Canada, on May 11 and 12, 1957. Further inquiries regarding program and hotel reservations should be addressed to

Miss Hazel Southard
2395 West 21st Ave.
Vancouver, B. C., Canada

PROMOTION FOR PRESIDENT

Col. Ruth Robinson, right, is congratulated by Col. Harriet S. Lee, Chief of the Army Medical Specialist Corps, Office of the Surgeon General.

Lt. Col. Ruth A. Robinson, Chief Occupational Therapist, Medical Service, Walter Reed Army Hospital, and president of the American Occupational Therapy Association, was among the four officers with the rank of major in the Army Medical Specialist Corps to be promoted to lieutenant colonel in the recently announced top ranks for women officers of the Army Medical Corps. This is the first time, since the establishment of regular Army status for women officers in the 1947 Army and Navy Nurses Act (Public Law 36), the section of dietitians, occupational therapists and physical therapists will have lieutenant colonels outside the three section heads. The chief of the corps, Col. Harriet Lee, is the only colonel.

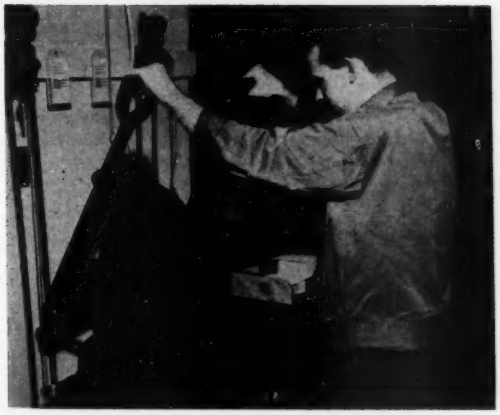
Selection was made by an Army selection board from the list of highly qualified individuals within the zone of consideration. Action is anticipated in the spring of 1957 for career incentive legislation which will further increase the number of lieutenant colonels, majors and captains within the corps.

Colonel Robinson's date of rank will embrace the almost four years of service from 1948 to 1952 she had in that rank as chief of the occupational therapy section, Women's Medical Specialist Corps (now Army Medical Specialist Corps). At the close of her tour of duty in that capacity, she reverted to the rank of major as no legal provision existed for more than one lieutenant colonel in the section. She served in that rank as chief occupational therapist at Fitzsimons Army Hospital in Denver before being assigned to Walter Reed Army Hospital.

The American Orthopsychiatric Association will hold its 34th annual meeting at the Hotel Sherman, Chicago, on March 7-9, 1957.

Picture Page*

Canvas bags of buckshot are used to give resistance on the brake pedal of a treadle printing press.



Hand printing press handles are removable and interchangeable from one press to another. This makes it possible to remove the handle from one and put it on another press, making the second press bilateral. Bilateral work of this type is often desirable, not only to treat both arms and shoulders, but also to prevent substitution of motion.

Resistance to arm flexion and shoulder extension is obtained on a hand printing press by attaching the handle of the press to a set of commercial weights mounted directly behind the handle of the press. The amount of resistance can be varied with a flip of a lever on the weights.

*Pictures from Fitzsimons Army Hospital, Denver, Colorado.

Picture Page

Overhead sling support is versatile for the treatment of upper extremities. It can be adjusted to standing or sitting positions. The rings are suspended from a pipe attached to the ceiling. Clothesline rope ties onto ring and the other end of rope inserts into a block of wood with holes at either end. Holes are just large enough to thread the rope through. Block of wood is used to adjust the length of rope. Shower curtain hooks and harness snap are shown in the picture attaching to the rope (the harness snap is more desirable). Heavy tension springs of varying strengths or in varying numbers are added next to support the weight of the arm.

Advantages: (1) *it is easily adjusted to individual patient,* (2) *higher suspension increases the arc of movement,* (3) *stability and adjustability make it more desirable for the patient to use,* (4) *spring and sling can be removed for storage and remaining rope pulled to wall end of pipe.*[1]

Leather glove used with quadriplegics to: (1) *protect sensitive hands from breakdown,* (2) *assist in propelling wheelchair by creating friction against wheel with use of rough texture of leather on palm side of glove.*[2]

1. Pictures from medical photography department, National Naval Medical Center, Bethesda, Maryland.

2. Picture from Veterans Administration, Richmond, Virginia.

NATIONALLY SPEAKING

Annual Report of the President

In this issue of AJOT you will find the reports of the standing and special committees of our Association as presented at the annual conference in Minneapolis. Excellent planning on the part of the editor, since the beginning of the year is a good time to review the record and to evaluate the blueprint of the coming months.

We cannot expect that each of us will be able to accept without reservation every report in its entirety. To differ is an individual's privilege and sometimes his duty. This is constructive because from differences of opinion coupled with understanding and interest are often synthesized the sound decisions that lead to true progress. We can expect, however, that each of us will read the reports with association goals in view and with an awareness that these reports are the work of representative groups from within the organization.

There is, of course, always the possibility that communication has broken down—a common failure in this era of the highly specialized. Semantics is not my field and I do not propose to discuss it. However, I would appreciate your indulgence while I point out certain attitudes that I find helpful.

We all recognize that every group develops a language pattern of its own, that words can have personally limited meanings, and that language is in a constant state of evolution. We also recognize that there can be a common denominator of understanding and that each of us has to contribute in the effort to find it.

In group situations such as ours, it seems to be assumed that the effort involved in communication is the responsibility of those who present. The receiver has responsibility too—his to try to read or hear what is said with an appreciation and understanding, not only of surface meaning, but meaning in terms of the ideas and concepts of the presenter. He must understand, not only in terms of his own needs, but those of the group that present, and the group as a whole.

Communication, like charity, should begin at home. If we cannot understand each other it is difficult to understand others. To be effective, communication must have something of charity in its truest meaning, and something of hope and faith. Hope and faith that with understanding we can together reach solutions, set and achieve goals, impossible to achieve alone.

Each report in this issue is the result of an inspirational amount of devoted group effort and many hours of work freely given from the store of leisure time. The work of our committees is the backbone and motivating force of our organization. It is on the basis of committee reports and recommendations that action is taken. The Board of Management and the national office proceed on these reports. Their work is a reflection of basic committee thinking.

If you cannot agree with a committee recommendation and have another suggestion or plan that seems more effective, it is your privilege to so state even if the report has been formally accepted. The committee chairmen will be pleased to hear from you directly or through the national office. Yours may be the idea that everyone has been waiting for; it may help to clarify thinking and point out weaknesses. Conversely, it may assure the committee that their original recommendation was a good one.

Ruth A. Robinson, Lt. Col., AMSC (OT)
President

Annual Report of Executive Director

Introduction. "Time for Reflection," our 1956 annual meeting theme is appropriate for the submittal of this report. We are at a healthy but critical stage of development as an Association. We are moving from the category of a small voluntary health agency to that of a moderate sized one with a role to be played, work to do, demands to be met and scope of service to be offered frequently on a scale comparable to the larger agencies with extensive resources both financially and numerically. We can be proud of our record to date. It has been achieved through sound and careful planning on the part of all of those connected with the Association through the years. In reviewing our gains and goals this year, let us keep in mind the words which President Eisenhower spoke in his speech of acceptance, "Our policies of today are right only in so far as they are designed to meet the needs of tomorrow."

This is the first annual report from our new national headquarters. It presents a summary of our activities with attention on the past six months (midyear report published in AJOT, May-June, 1956.) More and more the excellent work of the Association's committees and the education and publicity and recruitment offices, as reported and published, stand on their own merits and give a splendid accounting of our progress.

The wise coordination of all of the facets of this expanding program and the operational mechanics which make it function efficiently and productively are the major responsibility of the executive director.

Membership. Let us begin with a roll call. As of August, 1956, there were 4,000 paid members representing an increase of 104 over last year. Registered therapists totaled 5,085 (including seven secondary) which represents an increase of 301 over last year.

	1956	1955
Active Members	3,146	2,913
Sustaining	283	297
Associate	65	67
Assoc. Subscriber	68	75
Student	417	528
Honorary	21	16
	4,000	3,896

Non-Member Registrants	1,645
Practicing	876
Not Practicing	769

Financial Statements. By instruction of the treasurer, financial statements have been prepared for general, educational and reserve funds and grants showing (1) the budget for 1956, (2) actual income and expense for year ending June 30, 1956, (3) budget for 1957.

The deficit in the general fund which is the first since 1951 (annual balances have ranged from $5,000-$10,000) is primarily justified through expenses which include unbudgeted nonrecurring items such as moving the offices and the cost of establishing a new addressograph plate file. Balance in the educational fund is due in part to the increased grant from the general fund and the fact that the salary for the assistant was not drawn during part of the fiscal year.

After several years of negotiation, we are now exempt from the New York City sales tax, retroactive to January, 1956. This will save us considerable money annually.

Inside the national office.

(1) Personnel. We have had many changes during the year. Since the midyear report, we have added an additional secretary who serves the educational and general offices. On the professional staff we have lost Mrs. Wanda Edgerton, assistant in education and we have added Miss Rheta Glueck who has joined us as director of public information in the reactivation of the publicity and recruitment program under the National Foundation for Infantile Paralysis grant.

Mrs. Frances Shuff, who has tendered her resignation as assistant to the executive director, will be succeeded by Miss Helen Mathias as assistant director on November 19th. I wish to take this opportunity to express our deep appreciation to Mrs. Shuff for her outstanding performance while on the staff. She has rendered a valuable contribution to the Association with loyalty, enthusiasm and hard work.

The complete Association staff now totals 17 persons—14 full time and three part time. This includes the editor and secretary in the Milwaukee AJOT office with whom we maintain a close working liaison. Acknowledgment and thanks is hereby given to the loyal work of the staff members who serve the membership with spirit and efficiency.

(2) New quarters. The new office continues to be a daily boon in attractiveness and functional operation. We urge members to visit often and for those who are too far distant, interior photographs were taken for publication in AJOT. We are already utilizing to good advantage all of the space into which we anticipated we would grow.

Two new pieces of equipment should enable us to improve service. The Thermo-Fax duplicating machine literally serves as a secretary. The addressograph makes possible, through the tabbing classification, the categorizing of all types and combinations of membership and registration. This has never before been possible and it is a valuable addition. The setting up of the new stencil system has been a big job. It has involved the placing of approximately 20,000 colored tabs by hand on the individual stencils of members and registrants.

(3) Office procedures for billing, bookkeeping, membership and registration record files have been given a great deal of time and study through the winter and spring. We have made a critical re-evaluation of the plan and have prepared a standard operating procedure to remedy the failures and time lag of last year. We have done this under the guidance of Mr. Carr, auditor, who conducted the original survey for recommended changes.

The time schedule recommended by the Board at the midyear meeting to insure more prompt service to members and earlier publication of the Yearbook is being followed. This condenses the sending out of bills and receipt of payment into two and one-half months instead of the usual four months. This year the first membership and registration cards have been mailed out from the office within two weeks of receipt of payment.

Education office. Miss Heermans' report is indicative of the expanding responsibilities of the education office. She is to be commended on the manner in which she has conducted the various aspects of the program. The increasing importance of professional education in the present and future status of occupational therapy forces

us to recognize the major responsibility represented in this area.

Items of interest to be noted are: work has begun on a joint AMA-AOTA inspection of schools; an increase in the number of potential new schools located in medical centers or closely related; special study of field of interest indicated by applicants over a 10 year period; implications of maintenance of the registration examination assuming somewhat different proportions in scope and expansion, i.e., wide-spread locales of administration and increasing numbers of foreign graduates taking the examination.

The scholarship program is gradually and encouragingly growing. This is more fully reported under grants.

We express appreciation to Dr. Hyman Brandt for his continued help and guidance in the education office.

Publicity and recruitment. The appointment of Miss Rheta Glueck as director of public information has made possible the re-activation of the publicity and recruitment program under the continuing grant from the National Foundation for Infantile Paralysis. The six month interval without personnel was a serious drawback despite the continuing work of the state recruitment chairmen and their committees and the national office staff. The content of Miss Glueck's report represents only four months action and is indicative of the rapid pace at which the program is again going forward, i.e., contacts with recruitment chairmen and school directors, career literature mailings and distribution, newspaper releases and magazine contacts, new publications, film.

It is to be noted that one of the early slants in this year's program is emphasis on publicity via press releases at the national and local levels. Also the long awaited visual aid is taking shape in the form of a black and white movie film. Draft of the proposed script has been prepared for consideration.

Services to membership. Mrs. Shuff carries the major portion of these service activities and she is to be commended on her tireless efforts on their behalf.

(1) Newsletter, edited by Mrs. Shuff, continues to be a popular medium. A sincere effort is made to have it serve as a running account of Association activities. The number of special enclosures has increased this year—the current issue carrying four.

(2) Placement. Special effort has been made to keep up with requests and to afford consultations when desired. It is felt that better public relations have resulted. Enquiries relative to placement overseas and for general information have increased. This has required counseling regarding overseas needs and conditions of employment.

The "Positions Available" list was published in January with supplements in April, June and October. More than 600 lists have been sent to AOTA members requesting them. Schools have received copies as they are published. There are 435 positions listed in all areas of disabilities. Of these only 46 have been filled to our knowledge. A questionnaire is being prepared to be sent to all listed agencies, the return of which will enable us to keep the current list accurate.

Two hundred and ninety questionnaires have been sent to therapists. Replies have been received from 138. Of these 85 have been placed and 28 have taken positions listed in the job listing.

Salaries tend to fall within the staff and senior range with some differentiation for experience. Directors rarely start at the approved salary ($5,400, AOTA) and usually are offered the middle ($4,600) range for senior therapists. We have received many requests for our personnel policies in order to establish salary schedules but recognition of the therapist with ten or more years of experience is uncommon. This has caused some feeling among those experienced therapists desiring positions. It has been called to our attention that several have left the field for this reason.

We have had correspondence with agencies or individuals in Australia, Argentina, Bogota, Belgium, India and Mexico relative to setting up centers and recommending personnel. At the present time there are registered therapists employed in Australia, Africa, Belgium, Cuba, Denmark, England, France, Germany, Greece, India, Israel, Japan, Korea, Mexico, Panama, the Philippine Islands, Switzerland, Sweden, Scotland, Turkey.

(3) 1956 Yearbook. Changes this year include (a) Recognition of sustaining members, (b) Use of glued binding rather than the usual sewed binding. This has proven unsatisfactory and we will revert to the old form. (c) Holding of type over the year which has meant proofing from page rather than galley. This requires more time on the part of the editor and her assisting staff but it lowered the cost by approximately $900.00 and we will continue with the procedure.

Advertising decreased by ⅓. Advertisers have stated that response from therapists does not warrant continued advertising.

We are working closely with the special committee on the Yearbook relative to their recommendations for further improvements. It is anticipated that the current 1957 publication will be available approximately two months earlier than in the past.

(4) AOTA exhibit. The traveling exhibit has had the following schedule:

United Hospital Fund, New York City.
American Personnel and Guidance Assn., Washington, D. C.
Ohio State OT Association, Columbus, Ohio.
Lafayette Clinic, Detroit, Michigan.
Niagara Frontier Assn., Buffalo, New York.
AOTA Conference, Minneapolis, Minnesota.
New York State Fair, Syracuse, New York.
American Hospital Assn., Chicago, Illinois.
Chicago Jr. Assn. of Commerce and Industry; Chicago Medical Society, Chicago, Illinois.
American Public Health Assn., Atlantic City, New Jersey.

The AOTA exhibit has withstood the ravages of travel and use remarkably. After two years of active use it was returned to the company for refurbishing and now is in excellent condition. It is recommended that (1) use of exhibit be encouraged west of Chicago, (2) smaller (portable) and specialized exhibits be constructed to supplement the larger one which has been in circulation long enough to have repeat showings.

State Associations. We express appreciation to the several associations who have sent in financial donations. These have been designated for scholarships and national office expenses. We also express thanks to those who have assisted in the handling and coverage of the AOTA exhibit when national staff could not be present. Further thanks are expressed to those who have represented the AOTA at meetings in their locale. These are time consuming but professionally important tasks and the cooperation shown has been gratifying. The state associations, whose officers and members have participated in the above, include Illinois, Missouri, New York, Connecticut, Washington, D. C.

Recognition of the therapists who have thus represented the Association has been noted in the Newsletters.

We are working with the states on a guide outline they can use in preparing an annual report summarizing their status and activities. This material will be incorporated as a section in the annual report of our Association which it has been voted to publish as soon as possible.

Literature and publications. We are gradually building a field of available printed matter which is beginning to assume professional significance. This includes our technical reprints, manuals, textbooks, career literature, visual aids and miscellaneous materials and is well represented in our first leaflet on occupational therapy publications. All members received a copy with the September Newsletter.

The revolving publication fund which was established this year has begun to function and should prove a valuable asset in making possible the continued development of professional literature. The first two publications are Proceedings of the 1955 OVR Institute, and Objective and Functions of OT (1st installment of clinical procedures committee). The 2nd installment of Objectives and Functions is now in the press. Pending material is selected papers from the 1955-56 AHA-AOTA institutes on departmental organization and administration.

National office staff members have contributed to the writing of requested articles in *Mademoiselle, Encyclopedia* (published by Book Service America), *Hospital Management* magazine.

Handling of all of the above plus the regular correspondence entails a large-scale mailing operation. The metered mail count for the year is approximately 95,000 pieces. The outgoing bulk mail has totalled 4,207 packages.

Grants and foundations. Total grants received this year have amounted to $68,004.00 from four organizations. We are extremely grateful for their generous support.

1. (a) National Foundation for Infantile Paralysis for continuation of recruitment program —$23,850.00.

(b) NFIP for a basic curriculum study—$10,300.00. Funds being held in reserve by the Agency until initiation of study in 1957.

2. Office of Vocational Rehabilitation, Dept. of Health, Education and Welfare for four regional institutes—$10,000.00.

3. National Institute of Mental Health for psychiatric project—$24,154.00.

4. United Cerebral Palsy for undergraduate scholarships—$10,000.00.

The Office of Vocational Rehabilitation granted an additional sum totaling $36,590.00 for teaching and traineeships in 20 OT schools for 1956. They have already approved similar funds totaling $37,300.00 in 20 schools for 1957. These funds are granted directly to the schools in response to their applications.

OVR institutes. The four regional institutes were coordinated by Miss Martha Matthews in conjunction with the national office. A splendid piece of work has been accomplished in a brief period of time. Credit is due the coordinator and the local planning committees. Printed proceedings will be available.

Location and topics were:

Denver—Group Dynamics and the Team Approach in Rehabilitation, AOTA representative, Miss Heermans.
Richmond—Prevocational Techniques and Media, AOTA representative, Miss Fish.
Madison—Techniques of Instruction and Administration, AOTA representative, Miss Stattel.
Los Angeles—A New Approach to Occupational Therapy, AOTA representative, Lt. Col. Robinson.

Medical advisory council. Plans for the third meeting of the council have been completed for

the session to be held at the Palmer House, Chicago, October 6, immediately following the Minneapolis conference. Agenda items on which we will seek medical opinion include our recent publications, Objectives and Functions of OT, and the Guide for Professional Responsibilities of the Occupational Therapist; OT Reference Manual for Physicians; report of committee on recognition of non-professional personnel.

During the year council members have participated in Association activities: Dr. McCarroll, College of Orthopedic Surgeons, spoke at the AHA-AOTA institute in St. Louis; Dr. Rose, Congress of Physical Medicine, spoke at the OVR institute in Denver and he will speak at the institute in Minneapolis.

We have been informed of the appointment of Dr. Howard Wakefield, of Chicago, College of Physicians, to replace Dr. Alex Burgess.

World Federation for Occupational Therapists. Considerable work has been done in preparation for the council meeting of the World Federation to be held in Philadelphia, October 15-18. Miss Spackman and Miss Willard, U. S. delegate and alternate, respectively, have arranged for hospitality in cooperation with the Pennsylvania OT Association. The city of Philadelphia is cooperating in an official reception. Letters of welcome have been sent to the delegates of all member countries containing information on the Minneapolis conference, their arrangements for accommodation in private homes in both Minneapolis and Philadelphia, and a listing of clinical centers for visitation while in the United States.

The International Society for the Welfare of Cripples has extended an invitation for a reception and visit to the United Nations for those delegates who plan to be in New York City. The national office staff has worked with Mr. Donald Wilson on this.

Public relations and inter-agency contacts. The following listing of some of the meetings attended and participated in by national office staff and Association representatives during the past six months is of interest.

American Medical Women's Ass'n., Chicago, Ill.
Congress of World Confederation for Physical Therapy, New York City.
Joint Commission on Mental Illness and Health, Boston and New York.
National Ass'n. for Music Therapy, New York City.
National Ass'n. of Social Workers, St. Louis, Mo.
National Rehabilitation Ass'n., Atlantic City, N. J.
President's Committee on Employment of the Handicapped, Washington, D. C.
Veterans Administration, Washington, D. C.

Focus for 1957. Each year it has been my custom to recommend several selected items toward which we should try to direct special attention in the coming year to strengthen our total program. A review of these suggestions over a period of several years shows gratifying achievement. There are still two which have been previously noted and are not yet totally fulfilled.

(1) Vital statistics study. There is increasing need for current facts and figures about our profession in answer to numerous requests from au-authoritative groups, i.e., ratio of O.T.R.'s versus personnel in the aides and assistant non-professional categories; accurate percent of O.T.R.'s in the disability areas.

(2) Field service. Increased personal contact between national headquarters and Association personnel with state and local groups in an informational and advisory capacity.

Deep appreciation is expressed for the cooperation and help of the officers, executive committee, Board of Management, editor of the Journal, committee chairmen, each Association member and individual members of the national office staff. It has been a privilege to complete another year of work with you.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director

Annual Report of Educational Secretary

The following summary covers the activities of the education office since the last report presented at the midyear meeting with the exception of those concerned with the registration examination and the registration committee. Complete reports on the latter are contained in the annual report of the registration committee.

Area analysis and relative school standing. In accordance with the new procedure approved by the schools this year, an analysis has been made of the performance of the students on the two registration examinations administered in 1956. This analysis is again twofold: (A) a determination of the school's relative standing on the written part of the examination; and (B) a summary of the percentage of error made in fifteen subject matter areas by the students from each school.

This analysis was prepared for the 25 schools having six or more students taking the examination in 1956. The report on this analysis was forwarded to the schools early in September in order that the schools may take remedial action, if necessary, prior to the beginning of the 1956-57 school year.

In addition to the above regular services, the schools were also furnished with a chart comparing the rank of the relative school standing for the 1954-55 period with that for 1956.

Individual registration examination failure analyses. In addition to the area analyses and relative school standings prepared for the schools, the education office prepares similar analyses on an individual basis for those students who have failed the examination. Individual failure analyses have been prepared for 63% of the students failing in 1954, 31% of those failing in 1955, and 38% of those failing the February, 1956, examination.

Scholarships. The 1955-56 United Cerebral Palsy scholarship fund was administered through the schools of occupational therapy in accordance with the procedures established by the AOTA scholarship committee. Grants were made to 28 schools from this $10,000 fund on the basis of 94.5% of the average one year tuition for each school. Of the 262 students applying for scholarships, 54 received awards from this grant as follows:

Juniors	21
Seniors	25
Advanced Standing	5
Clinical affiliation	3

The total amount awarded was $10,023.75. Of this amount, $717.50 came from refunds of UCP awards made to students the previous year.

United Cerebral Palsy has continued their assistance to occupational therapy students for the academic year 1956-57. This $10,000 will be administered in the same manner as last year. The first half of the total award to each of the 28 schools was forwarded early in September. The awards this year equal 80% of the average one-year tuition for each school. The award to each school is less this year than last year for the following reasons: (1) increases in average tuition for 11 schools (increases range from $4 to $168 per year), and (2) there were no refunds from 1955-56 recipients.

The National Society Daughters of the American Revolution has established an occupational therapy scholarship fund. Disbursement of this fund will be made at the meeting of this organization's national Board of Management in October, 1956.

Joint AMA/AOTA survey of schools. A pilot survey of an occupational therapy school has been scheduled for the near future with John Hinman, M.D., assistant director of the Council on Medical Education and Hospitals of the AMA, and the AOTA educational secretary.

Prospective new schools. The University of Indiana is establishing a curriculum in occupational therapy. Freshmen students will be enrolled on the Bloomington campus this September. Students will enter the professional curriculum, on the Indianapolis campus, in September, 1958. The proposed curriculum has been presented to the AMA and AOTA for review. A curriculum in physical therapy is being established simultaneously.

An interest in the possibility of establishing a curriculum has been indicated, this past year, by the University of Florida; Boston University; Adelphi College; Arizona State College; Brigham Young University; Notre Dame College in New Hampshire; Ohio Wesleyan University.

	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	Overall 10-year Aver.
Physical disabilities	39	38	37	43	39	43	39	45	50	45	42*
Psychiatry	35	36	34	30	35	36	39	32	29	36	34
Pediatrics	12	14	17	14	12	13	15	16	14	12	14
Tuberculosis	9	7	9	7	7	7	4	5	4	5	6
GMS	6	5	3	6	8	2	4	2	3	3	4

*It is interesting to note that 7% of the overall 10-year average for physical disabilities is accounted for by an expressed interest in cerebral palsy which was doubled in this period (4.3-8.5%).

Table I

Study of field of interest of registration examination applicants, 1947-1956. The question, "In which disability field are you most interested?," has been asked of every applicant for the registration examination since 1947. A study has recently been initiated to determine the percent of interest in the disability fields of GMS, pediatrics, physical disabilities, psychiatry and tuberculosis. A total of 4,072 application blanks containing the requested information has been used in obtaining basic data for this study.

Percentages of interest in each of the five disability fields have been computed for each year and for the overall ten-year period. For purposes of this study, certain of the minor fields were included in the major five (for example, cerebral palsy has been included with physical disabilities). Because of this, there is some contamination of the data. The percents of interest listed in Table I are given in order of greater to lesser interest.

An analysis has also been made of the interest data for applicants from each of the twenty

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
250 West 57th Street, New York 19, N. Y.

September 15, 1956

EDUCATIONAL FACT SHEET

ACADEMIC*

Number of Approved Schools	29
Estimated enrollment, 1956-57	2517

Tuition*	Range	Average	No. of schools above average
1. In-state students	$50-900	$357.10	9
2. Out-of-state students fees (17 schools)	60-400	129.86	7
3. Composite of 1 and 2 above	$50-900	$422.03	8

*based on 28 schools (Puerto Rican school is not included)

Teaching staff	
1. Number of O.T.R.'s	1-10
2. Number of M.D.'s	2-27
3. Number of basic science instructors	0- 8
Medical advisory committee	
1. Number of schools having a medical advisory committee	23
2. Schools planning formation of such a committee	2
3. Number of M.D.'s on committee	2-15
4. Number of committee meetings	rarely-weekly
5. Responsibilities include:	
a. Consultation on course content	
b. Teaching	
c. Formulation of policy	
d. Consultation on student health	
e. Review of student affiliation report forms	
f. Review of registration examination results	
g. Counseling of students	
h. Approval of student affiliation programs	
Granting of degrees	
1. Number of schools granting degree before students start clinical affiliations	10
2. Number of schools granting degree before completion of clinical affiliations (2 to 6 months completed)	4
3. Number of schools granting degree after completion of clinical affiliations	13
Number of scholarship sources available	1-14

CLINICAL AFFILIATION CENTERS:

Number of clinical centers conducting student affiliation programs	258
Number of above affiliation centers per disability area:	
General medicine and surgery	70
Pediatrics	86
Physical disabilities	89
Psychiatry	75
Tuberculosis	60
Number of above affiliation centers offering student programs in	
one disability area	179
two disability areas	51
three disability areas	19
four disability areas	6
five disability areas	3

*Data on academic aspect has been compiled from the 1956 annual report on occupational therapy schools to the American Medical Association.

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schools which had 95 or more applicants over the ten-year period. The average, high and low percentages of interest per area have been plotted along with the overall average.

To further analyze the factors influencing these data, it is recommended that this study be continued to determine the relationships, if any, existing between the percentages of interest reported above and other related factors.

Institutes and workshops. The theme for the 1956 AOTA institute is "What Constitutes Treatment." More than 400 colored slides illustrating over 200 accounts of treatments given have been assembled during the past two years for study and discussion by the participants in this institute. Subsequent to this institute, the slides will be given to the education office for distribution on a loan basis.

The 1956 institute for occupational therapists sponsored by the American Hospital Association was held in St. Louis, April 23-27. "Organization and Administration" was the topic. There were approximately 50 students enrolled for this institute.

The 1957 institute for occupational therapists sponsored by the AHA is currently in the planning stage. It is proposed that this fourth institute be held in Seattle from April 22-26, 1957. The theme will be repeated this year for the West Coast.

The workshop session on item-writing to be held during the 1956 annual conference has been included in the annual report of the registration committee.

Publication of papers presented at AHA institutes. With the endorsement of the AHA, it is planned to publish in total, or in part, selected papers which have been presented at the occupational therapy institutes sponsored by the American Hospital Association in 1955 and 1956. The theme of both of these institutes was organization and administration. The resulting publication will be available from the AOTA, the price to be determined by costs involved in duplication.

Permission has been received from the authors to include the published papers covering the following topics: scope and function of OT; medical legal aspects of the work of the OT; charges for OT; utilization of non-professional personnel; elements of supervision; purchasing; recording and reporting; safety procedures in OT; community resources; standards for and organization of OT departments.

Education office field service. Since the 1956 midyear meetings, the educational secretary has attended meetings as a representative of the AOTA, visited schools, and has served as a member or cooperated with committees as follows:

Second congress, World Confederation for Physical Therapy.
Michigan Occupational Therapy Association.
Regional OVR-AOTA institute, Denver.
AHA institute for occupational therapists, St. Louis.
Colorado A & M College.
Kalamazoo School of Occupational Therapy.
Eastern Michigan College, Ypsilanti.
School of Physical and Occupational Therapy, affiliated with the University of Puerto Rico.
Washington University.
Wayne State University.
AOTA council on education and its committees.
OVR advisory committee on OT.
NIMH psychiatric OT project, executive and planning committees.
National Health Council, committee on education.
Planning committee for 1956 AHA institute for OT.

Other activities of the education office have been continued as reported in the past.

Sincere appreciation is expressed to the chairmen and members of the education committees, the Board of Management and the executive director for their support and cooperation.

Respectfully submitted,
Mary Frances Heermans, O.T.R.
Educational Secretary

Therapist Into Administrator . . .

(*Continued from page* 19)

worth a thousand graphs and studies. He is not often a creator, but even as spectator, as the common man, he can rise in ways his past performance would not predict. To aim at his common denominators in the name of ultimate democracy is to despise him, to perpetuate his mediocrities and to conceive him incapable of responding to anything better than the echo of his prejudices. . . . It is not in the nature of social engineering to be creative; it must necessarily be based on what is already existent. It can measure what is or what was . . . It cannot dream or conjure; it cannot find out from people whether they would like something new, something untried, because people cannot judge what they do not know. And they will not know until someone is damn fool enough to stick his neck out and have faith in his intuition, his perception and his hunches."

There is room for rugged individualism within the staff framework; room for these insurgents, these uncommon men and women to make their contribution to the patient and the agency and to claim in return the honest respect of other personnel. To the administrator falls the challenging job of placing such people in optimum positions to insure their productiveness, of providing the environment which will foster their creative effort.

The incomparable privilege of working with people, lay and professional, leads inevitably to a reaffirmation of principles expounded by great men in every era. Man hungers after beauty, goodness and truth. He seeks to experience life first-hand and in so doing develops a personal independence and esteem which sustain him through trial and tribulation. He seeks also to identify with mankind, to give and receive warmth, affection and love. He is a problem-solver and so dispels, inch by painstaking inch, the fears which beset his way. He responds to the challenge of perfection yet craves acceptance of his frailty. Although actually he may present a less than admirable figure, he is potentially superb. The practice of administration, like the practice of occupational therapy, is another way of recognizing these truths.

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Role of Occupational Therapy . . .

(*Continued from page* 12)

and for the benefit of psychiatry in general, it is hoped that there will be an ever-increasing understanding of other professional approaches to the psychiatric patient and better communication with other members of the psychiatric team and the hospital staff.

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5. Marianne Beran, Ph.D. "Projective Techniques and Their Application to Occupational Therapy." Proceedings of the Occupational Therapy Institute: A Reassessment of Professional Education and Practice in Occupational Therapy as Related to Rehabilitation, June, 1955, American Occupational Therapy Association, N. Y.
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8. Alfred H. Stanton and Morris S. Schwartz. *The Mental Hospital*. Basic Books, 1955.
9. Richard H. Williams, Ph.D. "Psychiatric Rehabilitation in the Hospital." *Public Health Reports*, Vol. 68, No. 11, Nov., 1953.
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Columbia University will offer a postgraduate course in cerebral palsy from March 4-May 3, 1957. The course, sponsored by the United Cerebral Palsy Associations, Inc., carries 8 points credit.

The number of registrations is limited; scholarships are available. For further information write:

Office of the Dean
College of Physicians and Surgeons
630 West 168th Street
New York 32, N. Y.

A one-week seminar in the principles and practices of homemaking training for the disabled is being given at the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, 400 East 34th Street, New York 16, N. Y. The seminar is sponsored by the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare and will be held March 18 to 23, 1957.

Letters to the Editor

To the Editor:

If more occupational therapists tried to write articles as well intentioned as this one, ("The Effect of the Professional Activity of Occupational Therapists on the Behavior of Mental Patients," Dec. 1956), the field would gain sooner the goal set by the authors: to prove that occupational therapists are effective in increasing patient activity. An attempt has been made to conduct a scientific evaluation of occupational therapists. In our opinion it fails to do so, but we hope that from our criticism many other therapists will be goaded into repeating similar experiments, for whether they succeed in proving the point (or even disproving it) they will gain for themselves and their profession a deserved respect.

Very small groups of chronically ill mental patients were exposed to exceedingly simple craft activities, with or without the supervision of a therapist, to find out the relationship between therapist activity and patient participation in activity. An attempt is made to show that the work of Dr. Hyde in this direction is of questionable validity. Dr. Hyde used acutely ill, short term patients from a very small research hospital in a very large city. When such patients were exposed to craft projects which carried their own printed instructions, they proceeded to work even though not supervised by therapists. In this article, long term patients from a larger state hospital in a very small city are discussed. Not one of the patients had been to occupational therapy in a year or more, an indication of their apathy or low intelligence, or both. The crafts to which they were exposed were not labelled, were not interesting, and to a considerable extent were not obvious, that is, "an assortment of colored jersey loopers," for example, which the patients were supposed to figure out were there to be sorted; by color? or by what? The samplings of the patient population and craft activities could scarcely have been more different. How could a comparison be made between the two hospital experiments?

An attempt is made to learn what difference there might be in patient reaction in response to the sex of the therapist, yet only one therapist of each sex was used. Since there may be a preponderance of feminine, masculine or even middlesex attributes to a man or woman, the sample becomes virtually meaningless unless we can be reliably informed that each therapist was selected for strongly sex-linked characteristics.

A conclusion is drawn that "These time sampling observations dispose of the notion that the occupational therapist is primarily a demonstrator of skills in various crafts." There is only one way to prove this. Instead of using a male therapist with one group and a female with the other, use an occupational therapist with one group and a craft teacher with the other. Who in organized occupational therapy could muster enough courage to do this? especially if the selection were random? Yet, until this is done, we shall not know.

We cannot agree with the authors in their dissociation of the elements which constitute *teaching*. We believe that "observations of patients performing task," and "suggestion of various ways of performing task" are just as much a part of teaching as "description of task."

There is one conclusion with which we heartily agree: "the increased use of occupational therapy aides." We have been trying for many years to influence organized occupational therapy to accept increasing responsibility in this area. Our only regret is that the conclusion is not justified by the experiment, for no aides were used in the present study.

Sidney Licht, M.D.

To the Editor:

I was delighted to find an article by Beatrice Whitcomb in the December issue. Here is not only a competent but gifted author and speaker in the field of supervision. Her many other articles should be read by all who supervise.

It is unfortunate that we are given only an abstract as, to this reader, some of the initial concepts seem loosely defined and confusing, such as ". . . the old distinctions between administration and supervision disappear within a modern functional program . . ." The author then adds that since the head therapist is concerned both with coordination of activities and overseeing she will not distinguish in the paper between administrative and supervisory functions. It is suggested that although this may be a valid point of view for the experienced supervisor, it would be more accurate to define administration as "the application of resources to objectives." In other words, it is all the activities which must be performed in order that the patient may be treated in accordance with standards, on a perpetual basis, and in relation to his total situation. Supervision falls under administration and is concerned with teaching, review and control of performance of personnel, itself a resource applied to an objective.

Thoughtful consideration of administration and supervision as thus defined will lead any therapist to realize that these functions are part of his *own* job on whatever level he functions. In fact, the attributes of the leader as given by Major Whitcomb should be those of *every* effective therapist. They should be studied and restudied: "intellectual competence . . . emotional stability . . . skill in human relations . . . ability to understand behavior in oneself and others . . ." There are many more and they are not easily learned but this article is a big start. And the list of references is excellent, including many fine articles from industrial management which has pioneered such extensive and valuable studies in this area.

Heartfelt thanks to and for one who has so much to give in these areas where we have so much to learn.

Carlotta Welles, O.T.R.

To the Editor:

I have read Mr. Brower's article in the November-December AJOT and welcome its effort to apply critical thought to OT technics in the field of cerebral palsy. While it might have been more pertinent to title the article, "Some Factors Inhibiting Progress of CP Children," since coverage of all factors would have to include the physical, intellectual and emotional components of the patient, the article nevertheless should be saluted as an effort in the right direction. The realization that therapy is teaching and that, as such, the teacher must be aware of the facets of both his pupils and his materials should help to erase sterile repetition of meaningless tasks.

Mr. Brower wisely chooses a circumscribed task (lacing) and evaluates the errors made in its execution. This is far more fruitful than depending upon the oft-used authoritarian coaching which allows no errors, inhibits independence, and defies analysis. Mr. Brower's methods for working around the difficulties show selected variety, and he wisely observes that "technics used for one child did not always work for another." In the postgraduate cerebral palsy course at Columbia University, we stress this individuality throughout all areas of treatment. No technic is held sacred or universally applicable. Rather, stress is placed on analyzing the needs (physical, intellectual, emotional and social) of the cerebral palsied person, on choosing technics dovetailing these needs, and on evaluating the subsequent interaction—always keeping on the alert for new developments.

Therapists seem to flood the professional journals with completely successful approaches—with so much success one wonders what keeps the chronic patient load so defiantly high. It is therefore, refreshing to read an article that resists enthusiastic impressionability but attempts to state errors perceived, to attack them open-mindedly, to keep trying new methods of attack and to report losses as well as gains within a stated patient load. More of this type of reporting and we will open the channels of efficient communication.

Sincerely,

(Mrs.) Isabel P. Robinault, O.T.R.

To the Editor:

Congratulations to the authors of "The Effects of the Professional Activity of Occupational Therapists on the Behavior of Mental Patients" in the November-December issue of AJOT.

This is the type of research—scaled to the limitations of the busy therapist—that should be participated in. It shows that we can validate some of the general statements which we make regarding the contributions of our profession. I hope we may have more therapists participating in like studies in the future.

Sincerely yours,

Muriel E. Zimmerman, O.T.R.
Chairman, Special Studies Committee.

To the Editor:

I want to congratulate both you and the author on the excellent and timely article by Dr. Brandt on our national registration examination which appeared in the November-December issue of AJOT. I know that those who worked with him at the conference in Minneapolis wished that more people could have learned the detail behind the functioning of this valuable tool. He gives, in an order logical to the layman, the pattern of our educational measurement as it has developed over the past ten years, and explains how statistics have proved the examination to be both consistent and valid, an outcome hoped for and projected from the start but one of which we could not have been certain except through many administrations and successive re-evaluations of the examination. He has also indicated to us what is necessary to maintain its efficacy, and to make the further gains that are desired and possible. A practical step in this direction was the item-writing session arranged for at the conference in Minneapolis.

The tremendous amount of work already contributed by OTR's who have worked together on related association projects is evidence of the general interest in this matter which is of vital concern to every profession—its measurement of professional qualification. We are fortunate that ours has been initiated and established through our own effort and continues to be validated by the methods known to modern educational psychology.

Sincerely yours,

Caroline G. Thompson, O.T.R.
Chairman, Council on Education.

Abstracts of ANNUAL REPORTS

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Hotel Nicollet
October, 1956

HOUSE OF DELEGATES

September 30, 1956

The meeting of the House of Delegates was called to order by the speaker of the House, Frances Helmig, O.T.R. Thirty-five states answered roll call; this represented all but two (Arkansas and Hawaii) of the affiliated associations. No new associations were accepted for affiliation at this time.

INTRODUCTIONS

1. *The president.* Greetings were given to the House of Delegates. It was pointed out that of 5,085 registered occupational therapists there are 876 who are practicing, who are not members of AOTA and it was stressed that each delegate has a responsibility to interpret the benefits that are gained professionally by members of the Association.

2. *Executive director.* A reminder was given concerning the new schedule of payment of fees with a deadline of November 16 and no time of grace. There is also a need for vital statistics in the national office which can best be secured through the states.

3. *Treasurer.* (See report to annual meeting and Board Report). A technical deficit has resulted this year because of moving the national office. This required some new equipment, and replacement or refinishing of old equipment. A reminder was given that the Association is losing over 8,000 dollars a year because of registered practicing therapists who are not members. Recognition was given Miss Spackman by the speaker for the nine years of a fine job well done.

4. *Secretary of the House.* As chairman of the credentials committee, the secretary reported several state association councils have asked for information regarding changes in their state constitutions. They have been advised to wait until the revision of house organs has been completed. Louisiana is pending approval.

5. *Vice Speaker.* Mrs. Bodine was appointed parliamentarian in the absence of Miss Martha Schnebly.

6. *Speaker of the House.* The speaker appointed Mrs. Patricia Bodine as parliamentarian; nominating committee to be Meryl Van Vlack, Corrine White and Patricia Bodine as chairman.

OLD BUSINESS

Committee on recognition of non-professional personnel. This committee is now a special committee of the Board of Management. The report was given for the information of the delegates and required no action on their part. If any state wishes to make further recommendations, the delegate should do so to the chairman of the committee, Miss Crampton.

Committee on revisions of house organs. This report was carefully considered point by point before it was accepted with thanks. It was voted that the report be taken back to the states for further recommendations; and that an expression with recommendations be sent to the speaker of the House by January 1, 1957. Chairman appointed: Miss Dorothy Deer.

Change of conference time. The House voted to recommend to the Board of Management that the annual conference be held in the fall of the year. This was done after a roll call vote indicated this was the most favored time.

Annual reports to AOTA. The House voted that presidents of the state associations be responsible for making multiple copies of the annual report and sending one copy to AOTA, one copy to the speaker and one copy to the secretary of the House. The due date is June 1. The House voted changes point by point in the guide outline and recommended to the Board that a composite of these annual reports be distributed to state associations. Delegate's report to AJOT. It was voted by roll call to continue the delegates' reports to AJOT.

Eleanor Clark Slagle lectureship. It was suggested that the delegates keep the awards committee report in their handbook, underlining important points. It is important that the blanks and additional information be carefully compiled. The delegates' job is to "clear the material" before sending to the speaker. The due dates to the speaker are:

1. Award of merit—two months before mid-year meeting, (February 1, is due date for 1957).
2. Eleanor Clark Slagle lectureship—four months before annual conference (June 1 for 1957).

Legislation and civil service committee. Announcement was made that the new chairman is Miss Virginia Caskey. Several items were reported: (1) Drafting of model classifications for three occupational therapy positions. (2) Salaries. (3) Discussion of the role of state legislation and civil service committee chairmen. (4) The role of the "non-professional." (5) Question of changing the committee name to "Committee on Standards" or "Committee on Professional Standards."

Fees for occupational therapy. The House voted that the speaker appoint a committee to draw up a questionnaire regarding fees which will be submitted for approval to the state associations. Chairman appointed: Miss Alice Clement.

NEW BUSINESS

Advertising plan. This was an information report stating that a pilot plan is in progress in the New York State Association whereby local soliciting is being done to secure advertisers for AJOT. A report as to results will be made at a later date.

Installation ceremony. The House voted to thank the Missouri Association for presenting the plan to the members but felt that it is a matter for each state association to decide.

Committee expense fund. The House voted to have the speaker secure information regarding committee needs and disseminate the findings to the delegates.

Special studies committee. The House voted that the suggestion to appoint a special studies committee chairman to act as liaison with the national committee be taken back to state associations. The delegate is to encourage this appointment. It was also voted that the chairman of the state special studies committee contact Miss Murial Zimmerman relative to acting as a liaison member to her national committee. The delegate is to report to Miss Zimmerman whether or not such a committee exists by January 1, 1957.

Occupational therapy definition. The House recommended that the Board of Management examine, review, and correct the definition of occupational therapy as it appears in all dictionaries at the present time.

Archives for House of Delegates. It was recommended to the Board that an Archives for the House of Delegates be established for the preservation of House records and documents of lasting importance.

Explanation of rights and privileges of auxiliary and associate members in state associations. The Rochester and New York Associations, in attempting to resolve differences and form one state association, found a major

difficulty in defining types of membership. They felt that other associations may have this same problem. The main discussion revolved around the group of registered occupational therapists who are not AOTA members. Also involved is the question "What are local issues and what are national issues?" The Rochester and New York Associations plan to send information to delegates in time to be reviewed along with the revision of the House Organs.

Lowered AOTA membership rate. The House voted to recommend to the Board that a committee be appointed to study lowered membership fees for non-practicing O.T.R.'s.

The House gave a rising vote of thanks to Miss Helmig for a job well done as speaker.

ELECTION OF OFFICERS

Speaker .....Mrs. Margaret K. Mathiott, O.T.R., Ohio
Vice Speaker ....Miss Marian Wright, O.T.R., Connecticut
Secretary .....Miss E. Dorothy Deer, O.T.R., Oklahoma
Delegates to the Board of Management
Miss Marian Crampton, O.T.R., Massachusetts
Miss Margery Peple, O.T.R., Virginia
Adjournment: 10:00 P.M.
October 4, 1956.

The meeting was called to order by Speaker Margaret Mathiott. After the roll call by the secretary, the speaker reported on the action of the Board of Management on House recommendations as follows:

1. The fall date for annual conference was approved.
2. Appointment was made of a committee to review the definition of occupational therapy and take indicated action to correct or edit.
3. Establishment of Archives in the national office was approved.
4. A committee to investigate lower fees for non-practicing registered therapists will be appointed.

Changes in the Yearbook will be governed this year by the budget. The meeting was adjourned.

Respectfully submitted,
Margaret K. Mathiott, O.T.R., *Speaker.*

Note: In reference to above minutes regarding: "Explanation of rights and privileges . . ." In considering this topic as you are considering revision of the "House Organs" some classifications used in states were mentioned to be: "State active," "inactive," and "past active."

1. Statement to complete first sentence of executive director's report: "if the name of the registrant is to be included in the 1957 Yearbook."

BOARD OF MANAGEMENT MINUTES

October 1, 1956

Roll Call

Members Present:

Ruth Robinson, Lt. Col.
Clare Spackman, O.T.R.
Beatrice Wade, O.T.R.
Florence Stattel, O.T.R.
Wilma West, O.T.R.
Sister Jeanne Marie Bonnett, O.T.R.
Mary Britton, O.T.R.
Mary Louise Franciscus, O.T.R.
Margaret Gleave, O.T.R.
Frances Helmig, O.T.R.
Ethel Huebner, O.T.R.
Elizabeth Jameson, O.T.R.
Arvilla Merrill, O.T.R.
Gertrude Murray, Capt.
Laurel Nelson, O.T.R.
June Sokolov, O.T.R.
Caroline Thompson, O.T.R.
Corinne White, O.T.R.
Elizabeth Whitaker, O.T.R.

Not Represented:

Dr. Donald Rose
Dr. Arthur Jones
Dr. William R. Dunton, Jr.
Ivabelle Rhodes, O.T.R.
Mary Crook, O.T.R.

Presiding—Lt. Col. Ruth A. Robinson, President

It was voted, as a precedent, that the newly elected speaker of the House of Delegates attend the meeting of the Board of Management, but without vote.

A letter of greeting from Dr. William R. Dunton was read to the group.

The president announced the new procedure of assignments to Board members to review specific committee reports prior to the meeting, in order to help clarify and speed the thinking prior to Board action. The Board was requested to evaluate this method.

Report of the treasurer, Clare S. Spackman, O.T.R. It was noted that the auditor's report and recommendations had been reviewed by the executive committee and met with concurrence of the treasurer-elect taking office at the conclusion of the current meeting.

A deficit of $4,615.20 in the 1956 budget was noted, due primarily to expenses incurred in moving the national office.

The finance committee requested an amendment to approve the 1957 budget, incorporating changes due to reorganization of the national office, and adjusting the expenditure figure for AJOT.

It was voted to amend the budget for the fiscal year ending June 30, 1957, in regard to expenditures and adjustments.

It was voted that insurance coverage for fire and theft at $40 for three years, and public liability at $12, be obtained, and that additional amounts be authorized as necessary for complete coverage.

It was voted that a full-time assistant in the education office be employed. This was recommended by the registration committee.

The report of the treasurer was accepted with appreciation and gratitude for the splendid record of service.

Report of the speaker of the House of Delegates, Frances Helmig, O.T.R. The House recommended that the annual reports of state associations should be submitted to AOTA by June 1, 1957. The speaker was requested to appoint a committee to make a survey of fees and prepare a questionnaire to be sent to state associations. The Missouri plan for installing officers was felt to be useful for a local association, but the House did not recommend country-wide acceptance. The majority wished the delegates' reports in AJOT to be continued. A request was received to discuss expenses for committee work. The House requested the speaker to investigate what committees would be involved, and the types of expenses, after which the matter could be referred to the state associations for recommendations.

The Board *voted* approval of the following recommendations from the House:

1. That annual conferences continue to be held in the fall.

2. That a committee be appointed to study definitions of OT for use in medical and other dictionaries and that a report be submitted at the midyear meeting.

3. That AOTA provide space in the national office for the archives of the House of Delegates.

4. That the House consider a study of lower membership fees for non-practicing registered therapists and that a committee be appointed to study this.

There was further discussion on the annual reports of state associations, for the purpose of compiling a report similar to that of other health agencies, and to include a section on the activities of state associations and the House of Delegates. Such a report would be printed, distributed to the state associations, and sent out to other health agencies.

It was voted to accept the report of the speaker of the House, in toto, with appreciation.

Report of the editor of AJOT, Lucie S. Murphy, O.T.R. The following points were presented for discussion:

1. Improved methods of circulation
2. The establishment of a closer liaison with committee chairmen and the national office.
3. Policy on publishing controversial material
4. The placement of ads on a sectional basis
5. Cooperation with the special studies committee
6. Pilot study of state associations soliciting advertising on a commission basis, similar to the New York Association (Metropolitan)

It was voted that the Western Pennsylvania Association and any other area interested in trying out this experiment be allowed to proceed, with the exception of the Midwest area which has a representative.

The Board was informed that the present circulation of the Journal is 4,816, roughly 1,000 more than eight years ago.

It was voted that a vote of thanks be given to Mrs. Murphy for her success, financial and content-wise, with the Journal.

Report of the executive director, Marjorie Fish, O.T.R. Progress relative to the annual billing procedure was reviewed to date. The first membership and registration acknowledgement cards were mailed out within two weeks after sending out bills.

Appreciation was expressed to Clare Spackman, retiring treasurer, for her cooperation.

A telegram was received with the information that Beatrice Wade had been elected to the board of trustees of the Joint Commission on Mental Illness and Health.

It was reported that the subject of a vital statistics study had been mentioned to the House of Delegates and that it should receive further study and consideration.

The handling of non-member subscriptions to AJOT has been transferred from the national office to the Journal office in Milwaukee.

The increasing number of non-member registrants who are practicing was discussed. A breakdown will be made on this with particular reference to geographical area, school, number of years since graduation and positions held. This information will be obtained from school directors, state associations and the non-members themselves.

Appreciation was expressed for the efforts of the secretarial staff and Mrs. Frances Shuff in the operational procedures of the national office, and for the new publications list prepared by the director of public information.

It was voted that the report of the executive director be accepted with deep appreciation.

Report of director of public information, Rheta B. Glueck; *Discussant*, Margaret Gleave, O.T.R. Possibilities for publicity were reported from the following organizations: The fall conference of the Women's Auxiliary of the American Medical Association to be held in Chicago; the United States Army Air Force; Hall of Health, Smithsonian Institute, Washington, D. C.; National Health Week of the American Hospital Association in May, 1957.

Cooperation with the American Hospital Association for the above would involve supplying 7,000 copies of a booklet and the fact sheet to be included in literature kits for distribution. It was recommended that we cooperate in this project.

The current NFIP grant provides $3,000 for a new recruitment film. The first draft of the script is ready and is being provided. The black and white film will run about 15 minutes. Prints will be available for the states at a nominal charge.

Discussion produced the recommendations that the 4-H clubs might be contacted for publicity; and that the states be encouraged to develop their own material to supplement that of the Association.

It was voted to accept Miss Glueck's report and that she be given an opportunity to develop the material she has covered so excellently.

REPORTS OF CHAIRMEN OF STANDING COMMITTEES

Report of the legislation and civil service committee, Laurel V. Nelson, O.T.R.; *Discussant:* Elizabeth Whitaker, O.T.R. Discussion pertained to the following points:

1. The desirability of the requirement for an A.B. degree. It was pointed out that this would not endanger therapists who could not fulfill this requirement but who had been working usefully for a number of years; it was merely a guide line for gradual improvement of standards in the future.
2. The question of changing the name of the committee to "committee on standards" or "committee on professional standards."

It was voted that the committee study the matter of a change of name and present a recommendation at the midyear meeting.

It was voted that the report be accepted with thanks, and that the committee be instructed to adjust with the council on education the item relative to the A.B. degree, and that publication of the model class specifications in an improved format be considered at a later date.

Report of the permanent conference committee, Winifred C. Kahmann, O.T.R. Discussion centered on consideration of the institute type of program for the 1957 conference; a change in the exhibitor's contract form; professional assistance with publicity for conferences.

It was voted that the 1957 Ohio conference committee be advised that the Board recommends consideration of a three-day institute workshop, to be supplemented by two days of general sessions, the decision for cancellation of such an institute to be determined by the advice received from Dr. Bradford and his associates whom President Robinson and Col. McDaniel will consult. If Dr. Bradford's opinion regarding the institute program was in the negative the Board still wished to retain the institute program as it has been in the past.

It was voted that the conference general sessions and institute fees be set at a minimum of $13 and a maximum of $16, to be pro-rated between general sessions and institute, and based on information relative to the expenses of an institute program.

It was voted to accept the invitation of the New York State Association (Metropolitan) for the 1958 annual conference.

It was voted that Denver be given first consideration for the 1959 conference, and if necessary, that Chicago be considered for second choice.

It was voted that conference dates be set for the fall season, as heretofore, during second or third week of October.

It was voted that travel expenses be allotted from the conference expenses, to permit the chairman to visit the conference site for the purpose of conference planning for the ensuing year.

It was voted to extend an invitation to the World Federation of Occupational Therapists to meet with AOTA in 1962 in Philadelphia, and that Philadelphia will be the site of the 1962 annual conference.

Report from the chairman of recruitment and publicity, Frances L. Shuff, O.T.R. Mrs. Shuff reported as the newly appointed chairman. The meeting of the recruitment committee was attended by 37 people from

16 states including representation from the Army and the Air Force. The recruitment effort for the coming year will be individual recruitment by individual O.T.R.'s toward a goal of 5,000 OT's. Media employed will include radio, TV, speakers' bureaus, hospital visits, Girl Scout merit programs.

With a view to planning reorganization of committee structure, a summary of all reports by chairmen will be made. A monthly letter from the recruitment chairman will be sent to all state committees. Quarterly reports have been suggested from state chairmen to the national chairman and director of public information. A questionnaire is to be sent to schools and recruitment chairmen which will survey recruitment needs and solicit information. An SOP for recruitment chairmen will be prepared.

It was voted that the report be accepted with appreciation.

Report of the special studies committee, Muriel Zimmerman, O.T.R.; *Discussant*, June Sokolov, O.T.R. It was pointed out that the concept of this committee is that the committee itself does not conduct research or special study projects, but that it helps individuals and groups to do so.

It was reported that the special tasks of interest to this committee were the compilation of a bibliography of all the articles in AJOT from 1945 to 1955, and the collection of material for the picture page of AJOT.

Some concern was expressed about the overlapping of function with the committee on graduate study and it was recommended that close liaison be maintained between the chairman of the above and the special studies committee.

It was voted that the report of the special studies committee be accepted with thanks.

Report of the educational secretary, Mary Frances Heermans, O.T.R. A study has been made to determine the percentage of students being trained in some fields in preference to others. The resulting material is an accumulation of basic data including different types of charts which delineate areas of interest and point out factors for possible future study when adequate personnel is available.

It was felt that a definitive listing of scholarship sources and requirements would be helpful, and it was recommended that state associations include this information on their annual reports.

Sister Jeanne Marie reported on the 1956 institute. She recommended that the schools be encouraged to use the material consisting of records of successful treatment and the collection of 400 slides on which the institute was based. An estimated 1,200 people were contacted in the preparation of this material.

It was voted that a hearty vote of appreciation be extended to Sister Jeanne Marie.

It was voted that the report of the educational secretary be accepted with thanks.

Report of the registration committee, Mary Frances Heermans, O.T.R. The committee recommended that a slight policy change be permitted, namely, the establishment of a "set" cutting percentage to be determined by a selected percentage of deviation from the mean for each examination. Essentially the cutting score would still be set individually for each examination but would be fixed in accordance with an established percentage below the mean for each examination.

It was voted to approve of this in principle only, and to permit the committee to proceed with investigation.

It was voted to change the date of the registration examination from the last Friday in February to the last Friday in January, beginning in 1958.

It was voted that a surcharge of $5.00 (or whatever the cost may be) in addition to the regular $15 examination fee be charged for all persons taking the examination in foreign countries, with the exception of Canada and Mexico, and should the regular fee be increased, the surcharge be maintained. Instruction should also be given that the answer book be returned by airmail, and the other sheets by sea mail.

It was recommended that several additional item-writing workshops, on a regional basis, be conducted.

A proposed revision in the AOTA international reciprocity policy statement was presented relative to clarifying whether or not the one year experience requirement for an O.T.R. must be met in the United States. The committee recommended that all experience requirements must be met in the U.S. The Board felt that such a statement attached to the reciprocity policy might be invalid.

It was voted that the proposed change be referred back to the registration committee for further consideration.

It was voted that the report of the registration committee be accepted with deep appreciation.

Report of the committee on recognitions, Capt. Gertrude J. Murray; *Discussant*, Corinne V. White, O.T.R. Capt. Murray's report suggested various categories of personnel for special recognition.

It was voted that a tangible, symbolic object be presented to the retiring president.

It was voted that the Eleanor Clark Slagle lecture be preserved in the national office in bound form as published.

It was voted that the report of the committee on recognitions be accepted with thanks.

Report of the council on education, Henrietta McNary, O.T.R. There was discussion with the representative of the American Medical Association relative to the establishment of a separate committee on OT education and elaboration of reasons for its support.

It was reported that a new school had been set up at Indiana University, and there were two future ones pending—the University of Florida in Gainesville and Boston University.

Many recommendations had emanated from the recently held OVR institutes and Miss Mathews requested that a committee be appointed to review the material.

It was reported that the council had adopted the proxy system similar to that of the Board, but with no vote.

The committee on graduate study was considering the publication of theses in graduate work and Mrs. Murphy offered to publish abstracts of the material in AJOT.

It was recommended that the council on education secure the services of an educational advisor and that this plan be tried out next year at the council meeting in Cleveland.

It was recommended that the suggestions in the SOP for the council on education be accepted without further question, as well as the recommendations regarding the handbook.

It was voted that the Board accept the report with thanks, and with a statement of appreciation for the work of the educational secretary in her cooperation with the council on education.

Report of the clinical procedures committee, Wilma L. West, O.T.R. The chairman added several points to the advance report, regarding the objectives and functions of OT. The first installment is available through the national office. The second installment will be available very shortly and will contain material on psychiatry and hematology.

No report was received from the section on mental retardation. Because of the growing significance of work in this field it was agreed that we should continue to study this problem and that further work should be done as soon as the subcommittee can be reorganized.

Over fifty pictures from the subcommittee on physical disabilities have been submitted to AJOT for publication, and have been cleared through the special studies committee. This subcommittee is abstracting regularly from professional journals and up to the present date has submitted 45 abstracts which are being used by Mrs. Murphy as fillers. Other subcommittees plan to enter this abstracting plan for the Journal, which it is hoped can be developed into a permanent and regular Journal feature.

It was voted to accept this report with a very sincere expression of admiration for the committee which has made an excellent contribution to the literature in the field.

REPORTS OF CHAIRMEN OF SPECIAL COMMITTEES

Report of the committee on OT reference manual for physicians, Marguerite Abbott, O.T.R. This report was presented by Miss Franciscus in the absence of the chairman. Five first drafts have been received. It is anticipated that the manual will be completed within the next six months.

It was voted that the report be accepted with an expression of appreciation.

Report of the committee on the history of occupational therapy, Lucie W. Nagy, O.T.R. A brief progress report was read by the executive director in the absence of the chairman.

It was voted that the report be accepted with sincere appreciation.

Report of the national OT research laboratory, Capt. Cordelia Myers. The report was submitted to members in advance of the meeting.

It was voted to accept the report with thanks.

Report of committee to plan implementation of recognition of non-professional personnel, Marion Crampton, O.T.R.; *Discussant*, Florence M. Stattel, O.T.R. Copies of an additional report, "Correlated Study of Comments from State Associations," were distributed to the Board, which augmented the interim report for advance Board information.

It was voted that the name of the committee be changed to the "committee on the recognition of OT aides."

It was voted that the term "non-professional" be avoided in all OT literature and correspondence.

The question of establishing minimal essentials for a training program for OT aides was discussed. A possible title, "Suggested Programs for the Training of OT Aides," was proposed.

It was voted that this be referred to the executive committee for further study in the light of its importance to the whole profession.

It was voted that the report of the committee, as amended, be accepted with thanks, and that its members be requested to continue their work and report back to the Board with a full statement when their study is nearer completion. (See further report in the minutes of October 3rd.)

Report of the special committee on SOP for committees, Helen Willard, O.T.R.; *Discussant*, Caroline Thompson, O.T.R. The modification was noted that the deadline for the submission of reports to the national office should be at least six weeks before any meeting at which the report was to be presented.

It was voted to adopt the recommendations presented: (1) That all committee chairmen should be given the list of procedures presented on pages 3-6 (IV) of this report and that careful check should be made of the efficacy of this guide list with the idea of making it a permanent one. (2) That copies of these SOP's should be available in the national office for the guidance and instruction of all new chairmen and committee members and that they be re-evaluated following a trial run of approximately one year. It was recommended that the committee which set up the report should be the one to give the suggestions after the trial run and evaluation. The chairman stated that the committee would be willing to continue its work as indicated.

The report was accepted with appreciation for its comprehensiveness.

Report of the development plan committee, Wilma West, O.T.R.; *Discussant*, Beatrice Wade, O.T.R. Discussion brought forth the following considerations: The importance of determining what the organization can undertake and carry through; corollary problem of widening participation; proportion of work to be carried by the national office; evaluation of actual practice as contrasted with extreme concentration on education, the time element involved.

It was voted that recommendations of the development plan committee be followed in the assignment of priority ratings to future grant projects and establishment of a tentative time schedule.

The following recommendations were made for the next assignment: that the committee should carry the responsibility of acting in an advisory capacity; that it should no longer be limited to executive committee members; that the chairman should be free to call on other members of the Association for assistance; that appropriate sections of the material contained in the report should be made available to the membership at large.

The report was accepted with appreciation.

October 3, 1956

Roll Call

Members Present:

Ruth Robinson, Lt. Col.
Wilma West, O.T.R.
Beatrice Wade, O.T.R.
Florence Stattel, O.T.R.
Mary Britton, O.T.R.
Marion Crampton, O.T.R.
Marie Louise Franciscus, O.T.R.
Margaret Gleave, O.T.R.
Ethel Huebner, O.T.R.
Myra McDaniel, Lt. Col.
Margaret Mathiott, O.T.R.
Arvilla Merrill, O.T.R.
Elizabeth Messick, O.T.R.
Laurel V. Nelson, O.T.R.
Margery Peple, O.T.R.
June Sokolov, O.T.R.
Caroline Thompson, O.T.R.
Elizabeth Whitaker, O.T.R.

Not Represented:

Ivabelle Rhodes, O.T.R.
Sister Jeanne Marie (proxy held)
Mary Reilly, O.T.R.
Dr. William R. Dunton

Presiding—Lt. Col. Ruth A. Robinson, President

President Robinson opened the session by extending a welcome to the new and re-elected members of the Board.

Committee on recognition of OT aides. The executive committee submitted the following recommendations:

1. That the committee on recognition of OT aides be lifted from committee status to project status, and that expenses entailed in traveling to the national office for meetings should be charged against the travel expense account in the general fund, and should not exceed $200.00.

2. That the previous charge of this committee be

changed to involve: (a) Setting up the framework for the recognition and training of aides in OT in all fields. Civil service implications should be carefully considered. (b) Working out of details of a suggested curriculum.

It was voted that the recommendations of the executive committee be accepted.

Report of the committee on the selection of the Eleanor Clark Slagle lectureship. Miss Ruth Brunyate was elected to this honor for the 1957 lecture and officially accepted same.

REPORTS OF COMMITTEES OF THE BOARD OF MANAGEMENT

Report of the committee on the Yearbook, Ethel Huebner, O.T.R.; *Discussant,* Marie L. Franciscus, O.T.R. The discussant made the following points: That the recommendations would substantially increase the work of the national office; that the suggestions should be divided into two categories, those requiring minor changes, and those involving the publication of additional material; that the officers and members of the House of Delegates should be listed; that the statement on the meaning of registration, and adequate mailing addresses for schools could be managed easily; that abbreviations might be more acceptable than code; that inclusion of "Formation and Function of the House of Delegates" and the "Constitutional Guide" might prove helpful, but would involve considerable cost; that the statement regarding advertisers might prove helpful to them and not affect cost appreciably.

The executive director reported that each additional page will cost approximately $17.00. It was felt that the recommendations were excellent and the briefer and less costly ones could be incorporated in the 1957 Yearbook. The recommendations involving more drastic changes and marked increase in cost should be held in abeyance for possible inclusion in the 1958 Yearbook, pending further study.

It was voted that those revisions not involving additional cost, and not leading to a delay in early publication, be accepted—this to be left to the discretion of the executive director.

Report accepted with appreciation.

Report of the committee on reimbursements and accommodations, Florence M. Stattel, O.T.R.; *Discussant,* Arvilla Merrill, O.T.R. Recommendation was made that the policy of AOTA should include the reimbursement of executive committee members for expenses incurred in attending the medical advisory council meeting. This is standard procedure for organizations of similar nature and size.

It was voted to accept this recommendation as a philosophy and attempt to implement it further when the budget permits such an expenditure.

It was voted to accept the recommendation that, in the light of the financial structure at the present time, ways and means of increasing our funds be considered so that reimbursement can be made.

It was voted that the recommendation to give token amounts toward meeting expenses be considered by the treasurer in the 1958 budget and further action be postponed until that time.

It was voted that the time of the meeting of the medical advisory council should be determined by the need of Association business, or the need to orient the medical personnel, and should be set from year to year, with preference given to the midyear.

It was voted to accept the recommendation to allot accommodations to officers of an association. It is therefore recommended that the accommodations be divided as follows: (a) president (b) first vice-president or president-elect (year in which the latter takes office) (c) treasurer (d) chairman, permanent conference committee.

It was recommended that the SOP of the permanent conference committee should contain a flat statement that a minimum of four accommodations should be complimentary when selecting a hotel for the annual conference.

It was voted to table the recommendation that AOTA should assume full or partial expenses of the speaker of the House of Delegates at midyear meetings and annual conferences.

It was voted to request a small committee to study methods of cutting expenses and investigating possibility of obtaining increased revenue.

It was voted that the report be accepted with the indicated changes.

GRANT PROJECTS

OVR 1956 institutes. Full report given at annual business meeting. Proceedings will be compiled for publication.

NFIP curriculum study. A progress report will be prepared by the executive director, and sent immediately to the National Foundation for Infantile Paralysis. The total proposal will be ready for the NFIP by March 1, 1957. This application will propose a three to five year plan, with budget allocations for three major phases. In the proposal it will be stated that implementation will not be initiated until four months after the grant is made, contingent upon the availability of suitable personnel.

OTHER BUSINESS

AOTA personnel policies. No report at this time due to the resignation of the chairman at a time when it was not feasible to appoint a successor. Miss Huebner has consented to accept the chairmanship of the committee.

It was recommended that a committee be appointed to study the matter of the orientation of new Board members, and that an SOP be prepared.

It was voted that a vote of thanks be extended to the national office secretarial staff for their efficient and loyal work.

Midyear meeting. It was voted that the next midyear meeting be held in St. Louis, Mo., the weekend of April 5, 6, 7, 1957, with an alternate date of April 12, 13, 14.

Report on the medical advisory council, Marjorie Fish, O.T.R. The agenda items for the October 6 meeting in Chicago were presented to the Board. The replacement of Dr. Alex Burgess, College of Physicians, by Dr. Howard Wakefield was noted. Some of the new business to be transacted by the medical advisory council will consist of current and special projects, and items arising from the 1956 AOTA annual conference.

1956 WFOT council meeting, Clare Spackman, O.T.R. The Board was advised briefly regarding the agenda items to be discussed at the council meeting of the World Federation of Occupational Therapists in Philadelphia, October 15-19. These were concerned with the establishment of international standards for OT's in relation to professional ethics, relationships and procedures; scope and limitation of the professional field; qualifications for personnel on international exchange; application for non-governmental status in the World Health Organization.

It was voted to extend a vote of confidence to the three AOTA representatives (delegates) attending the council.

Correspondence. A letter from Miss Bertha Piper suggested that the Newsletter might be published on a bi-monthly basis, and the saving of $800 applied to a fund to help defray committee expenses. The letter had also been sent to the House of Delegates for consideration and the speaker's report to the Board of Management contained the recommendation that the possibility of establishing a committee expense fund be considered. It was the feeling of the Board that the Newsletter was too vital to be curtailed, and that money from donations might be used for a committee expense fund.

It was voted that the Newsletter be maintained on a monthly publication basis.

It was voted that appreciation be expressed to Miss Piper for the substantial thoughts she presented.

A letter from Dr. Knudson contained an announcement of the appointment of George D. Frye, O.T.R., as the successor to Miss Dorothy Rouse, O.T.R., as chief occupational therapist of the Veterans Administration.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director

EDITORIAL REPORT

In the absence of Mrs. Murphy, I am presenting the editorial report. There are two points which Mrs. Murphy wished to discuss:

Point 1. When an article is submitted to her office, it is first read to make certain that the material is suitable for an article or might be better used as an editorial or as material for the featured occupational therapy department sections. If it belongs in the front of the book, the article is sent to the division editors for evaluation and no effort is made to influence the decision which the division editors render. Each article is judged on its own merits as evaluated by the division editors of that area. The editors, however, are confined to their own areas and have no idea of the number or range of articles beyond their jurisdiction. The truth is that we have scheduled for the coming issues some of the best articles we have ever had. At the same time we have not increased in quantity. Writing for a professional magazine brings prestige to the department having an article published, it brings professional prestige to the author and its benefits the professional association because it disseminates information which enables professional growth. Therefore, our editor urges: will you please write, will you please persuade your co-workers to write, and will you persuade your doctors and others on your professional team to contribute articles.

Point 2. We cannot publish a magazine without money and if you do not want to use money paid from your own pockets, you have to support our advertisers. If you think these are limited, then get suppliers that you like to deal with to advertise. But when you support non-advertisers you make it difficult for those loyal to us, you cut down the chances for selling an advertiser a repeat schedule and lessen the future success of the Journal. With your help the Journal can be self-supporting. Without your help, an advertiser can be sold only once. Your cooperation is needed and our editor does not hesitate to ask for it because it is one way you can help the Association at no cost to you—in fact it defrays costs and you reap the benefit. Mrs. Murphy realizes that there are many reasons why you do not buy from advertisers, but wishes you to remember that it is to *your* benefit to either buy from advertisers or get suppliers you do buy from to advertise. It doesn't matter which method you use, the end result is to your advantage.

Lt. Col. Myra McDaniel, O.T.R.
Associate Editor.

MIDYEAR MEETING
BOARD OF MANAGEMENT
American Occupational Therapy Association
Hotel Coronado
St. Louis, Missouri
April 5, 6, 7, 1957

REPORT OF THE TREASURER

The financial report for the Association for the fiscal year ending June 30, 1956, for the general, education and reserve funds has been distributed.

For this year there is a technical deficit of $4,615.20. This is caused primarily by the moving and refurnishing of the national office. The treasurer believed that it could be absorbed as in the four previous years there had been an excess of income over expense varying from $6,000.00 to $10,000.00.

In the light of the present figures the Board, upon request of the treasurer and the finance committee, amended the approved budget for the fiscal year which ends in June, 1957. This amendment results in a deficit for the general fund of $2,226.00.

There is money in the reserve fund to cover this. It is hoped, however, that this sum and more will be obtained through the drive to bring into the Association the 876 registered and working therapists who are not members. Each of you can help in this by checking in the Yearbook the membership status of your colleagues and by explaining to them how they can contribute to the growth of our profession through Association activities, for truly the slogan of the original 13 states "Together we stand, divided we fall" applies to our profession today.

The "Nationally Speaking" column of the July-August edition of AJOT, page 195, presents to you my considered thought on our financial picture. One point from this I wish to again emphasize. Much of the work of our Association is done through committees. Each year, more is demanded of the membership. How much longer can the many occupational therapists serving on committees continue to contribute not only their time and effort but also pay for their travel expenses. How many do not serve on committees because of this financial drain.

Our present financial status is such that this year at least economy must be our by-word. It is for you, the membership, to determine our future.

In turning over the treasurership to Miss West, I feel that in every way but one she is equipped to handle it. Unfortunately, she is not an alchemist or a magician who can turn pennies into dimes.

I am, therefore, going to ask her to accept as a gift, a magic block which turns pennies into dimes. I do this in the hope that with your cooperation she may not need to penuriously pinch pennies.

Respectfully submitted,

Clare Spackman, O.T.R.
Treasurer

FINANCIAL STATEMENT
General Fund

	Budget Year Ending 6-30-56	Actual Income & Expense Year Ending 6-30-56	Budget Year Ending 6-30-57
INCOME:			
Registration Fees	$ 34,200.00	$ 36,011.16	$ 36,000.00
Membership Dues	25,000.00	25,651.00	27,000.00
AJOT Subscriptions—Members $11,711.00) —Others 3,982.95)	16,000.00	15,693.85	16,000.00
AJOT Advertising	12,500.00	12,990.75	12,500.00
Sales of Reprints, Insignia, Pins	3,200.00	2,110.99	3,200.00
Sales of Yearbook Copies	200.00	180.00	100.00
Yearbook, Advertising	2,400.00	1,254.02	2,000.00
Volunteer Course	75.00	92.25	75.00
Conference 1955	7,500.00	9,731.64	8,000.00
Interest Bank & Bonds	650.00	1,032.08	750.00
Donations	200.00	210.00	200.00
	$101,925.00	$104,957.74	$105,825.00
EXPENSES:			
Salaries—Professional $11,125.68) Secretarial 14,107.77)	$ 25,040.00	$ 25,233.45	$ 29,533.00
Temporary	350.00	2,347.25	1,670.00
Travel	3,000.00	2,204.53	2,500.00
Cooperation with Others	300.00	279.07	400.00
Recruitment & Publicity	2,500.00	1,835.96	1,000.00
Exhibits	500.00	617.40	500.00
Office Repairs	200.00	122.06	200.00
Postage & Expressage	2,000.00	2,193.94	2,000.00
Books & Subscriptions	150.00	82.83	150.00
Rent & Light	5,200.00	4,723.21	5,946.00
Telephone & Telegraph	700.00	920.74	900.00
Legal & Auditing Fees	550.00	581.00	500.00
Gratuities	125.00	116.50	125.00
Grant to Educational Fund	9,095.00	9,095.00	9,600.00
AJOT—Cost & Expense $26,207.87) AJOT—Disc. & Commission 1,971.63)	25,000.00	28,179.50	27,100.00
Yearbook Postage	1,600.00	1,773.69	1,700.00
Yearbook Printing	7,200.00	6,511.35	7,000.00
Conference 1955	6,000.00	8,388.58	6,000.00
Newsletter	1,800.00	1,898.60	1,900.00
Materials purchased for Resale	2,500.00	1,803.96	2,000.00
Office Supplies & Expenses	2,200.00	5,115.60	2,500.00
Printing	1,800.00	1,831.42	1,500.00
Taxes & Insurance	1,200.00	1,071.19	1,252.00
Miscellaneous	75.00	39.70	75.00
Natl. Office Procedure Consult.	200.00	335.00	200.00
Purchase of Bond	500.00	500.00	500.00
Furniture & Fixtures	100.00	—	—
Depreciation	500.00	596.39	700.00
Consultancy	—	618.00	600.00
Contingency Fund	1,540.00	—	—
	$101,925.00	$109,572.94	$108,051.00
	DEFICIT:	$ 4,615.20	$ 2,226.00

Educational Fund

	Budget Year Ending 6-30-56	Actual Income & Expense Year Ending 6-30-56	Budget Year Ending 6-30-57
INCOME:			
Grant from General Fund	$ 9,095.00	$ 9,095.00	$ 9,600.00
Registration Examination Fees	9,000.00	8,028.50	9,000.00
Initial Registration Fees	6,000.00	5,260.00	6,000.00
Sale of Educational Materials	1,000.00	1,247.10	1,000.00
Conference Institute 1955	2,000.00	1,808.50	2,000.00
Payments for Special Services	2,000.00	1,639.72	1,200.00
Interest on Bank Balance	70.00	115.82	75.00
	$ 29,165.00	$ 27,194.64	$ 28,875.00
EXPENSES:			
Salaries—Professional $6,348.63) —Secretarial 2,776.26)	$ 13,450.00	$ 9,124.89	$ 11,900.00
—Temporary	300.00	—	—
Travel	2,000.00	1,329.52	1,837.00
Office Repairs	200.00	5.74	100.00
Postage & Expressage	400.00	347.03	450.00
Rent & Light	2,800.00	2,298.63	3,413.00
Telephone & Telegraph	240.00	318.23	275.00
Legal & Auditing Fees	150.00	259.00	200.00
Conference Institute 1955	2,000.00	1,429.27	2,000.00
Materials purchased for Resale	900.00	1,187.37	900.00
Office Supplies & Expenses	350.00	565.50	400.00
Printing	350.00	630.99	400.00
Taxes & Insurance	300.00	254.92	300.00
Miscellaneous	75.00	15.00	50.00
Consultancy	2,500.00	5,237.87	3,000.00
Computations	700.00	516.00	700.00
Special Services	1,200.00	898.00	1,200.00
Examination Expenses	550.00	1,213.58	750.00
Committee Expenses	300.00	315.49	500.00
Registration Examination Items	—	29.00	500.00
Contingency Fund	290.00	—	—
	$ 29,165.00	$ 25,976.03	$ 28,875.00
		BALANCE: $ 1,218.61	

A.O.T.A. Reserve Funds and Grants

as of June 30, 1956

I. *Reserve Funds*

Total Cash in Banks and on hand (Balance of Grants *not* included)		$39,785.83
Cash in Chase on hand:	$17,380.73	
Cash in Savings Banks	16,695.80	
Publication Fund	4,094.54	
Other Assets	7,756.32	
Accts. Rec. $1,826.70)		
Def. Charges 5,929.62)		
Liabilities		
Equipment Fund	291.28	
Reserves	1,375.87	
Scholarships: $1,343.87)		
Resch. Proj. 32.00)		
Accounts Payable (Taxes & Commissions)	2,474.41	
Investments—U. S. Govt. Bonds		$23,600.00
Gen. Fd.: $5,100.00)		
Endowment Fd: 18,500.00)		

II. *Grants*

1) N.F.I.P. III	$23,850.00	Balance	$19,789.30
2) U.C.P.	10,000.00	Balance	—
3) O.V.R. II	10,000.00	Balance	6,298.75
4) N.I.M.H.	24,154.00	Balance	17,534.76
Total of Grants:	$68,004.00		
Total of Balances			$43,622.81

CLINICAL PROCEDURES

The first installment of material compiled by this committee was published in May, 1956, and, as previously announced in the Newsletter, is available from the national office at $1.65 per copy. It includes an introduction, a synthesis of treatment objectives by specialty area, 13 diagnostic studies on general medicine/surgery, one on tuberculosis, and 11 on physical disabilities.

The second installment was released this past week and a sample of it, as well as the first, is included among the educational exhibits at this conference. This includes formulations on psychiatric conditions and may be obtained from AOTA at 50c per copy.

Publication of the third and final installment is anticipated for early 1957. As soon as it becomes available, it will be announced in the Newsletter, together with information on cost which will be proportionate to those already published. This final material will cover pediatrics, cerebral palsy and administration. In all, the three installments will include a total of 40 diagnostic studies plus a definition and analysis of the functions of the occupational therapist which are exclusive of treatment.

The subcommittee on physical disabilities has engaged in two additional activities this past year. First, acting as a collecting service for AJOT, it has submitted to the magazine some fifty photographs and drawings for adapted equipment for the picture page. Second, it has organized an abstracting service for the magazine and, covering 16 professional and medical journals, has submitted 45 abstracts for publication in AJOT. To date, these have been used largely as filler material but it is hoped that they will eventually form a separate section of the Journal and include abstracts in fields other than physical disabilities. Arrangements for this are being worked out with the editor for eventual absorption by the magazine as a regular and permanent section and service of AJOT.

At this stage of our development, I would remind the Association membership that our committee was originally established to compile source materials for the practicing therapist. We have taken the first step toward this end in the publications already released and those which will follow early in 1957. These materials are in no way considered the last word on professional doctrine but rather are seen as a beginning on which further growth and development of statements on and interpretation of our treatment service can be built. The committee would be the first to feel their efforts had been in vain if there were universal agreement on or satisfaction with this material. We hope that you will both challenge and test it, and that you will contribute to its continuing revision that it may keep pace with the growth within and about our profession.

In developing the material in this publication, we started with the specific and worked toward the general—i.e., we formulated outlines of diagnostic studies of conditions frequently referred to occupational therapy. Our next effort, already under way in the two subcommittees which completed their first assignments early, is to translate these studies into the basic or general approach to occupational therapy based on patient needs. This must be accomplished by pulling from the specific studies the common elements which characterize occupational therapy's service to the patient regardless of his diagnostic label.

My resignation as chairman of this committee has been submitted with a feeling of sincere gratitude to: the preceding president, for her vision in establishing this committee; the current president for her trust and encouragement in our work; the national office staff for their assistance with the mechanics of publishing our material; the subcommittee chairmen and members for their time and devotion to professional service which has made possible our publications; and to the dozens of other occupational therapists throughout the country who have been called upon to write, review or revise our final outlines.

Respectfully submitted,
Wilma L. West, O.T.R.
Chairman

SPECIAL STUDIES COMMITTEE

The special studies committee, this year having a new chairman and membership, assigned itself as its first task the job of orientation to the past efforts of the committee and an assessment of its future purpose.

At the same time we were requested to formulate standard operating procedures. In writing this we simultaneously gave expression to what we considered the functions of the committee should and could be and in what manner it should operate.

Briefly, I should like to present the intentions of this committee as we have defined them, which is as follows:

To encourage, assist and coordinate those interests and efforts of individual members of our profession who either wish to be or are already engaged in research or special studies. (It is not the intention of the committee itself to carry out any research project, although some of its members may be doing independent research simultaneously. Most of them are research minded and have been selected as members because of their interest and ability in this direction.)

The above program will be carried out by:

(1) Continuation of collection of problems that still confront the individual occupational therapist.

(2) Checking these problems to confirm whether or not someone else may have already solved them or be attempting to solve them, and making that information available to the person or persons needing help.

(3) Assistance, if requested, in the form of advice or guidance to the people who have already formulated an interest into a special study.

(4) Coordination of similar problems or studies, where this is possible, so that our individual work is reinforced by joint effort.

(5) Recording or filing information regarding independent studies to be made available to anyone interested.

So that these functions can be adequately handled, the committee is in the process of expanding its membership. We have invited as consulting corresponding members several representatives from each of the disability areas to increase our ability to give assistance. We are also inviting, as liaison members, the chairman of the special studies committee from each state. Since not every state has such a representative—indeed we know of only two at this date that have—we have requested, through the House of Delegates, that each state consider appointing such a person. It was our feeling that only through such liaison would we be able to reach the total membership.

To implement our objectives and functions as outlined, our other activities to date have been the following:

(1) Investigation into the availability of bibliographies to be used as source material in supplying information. Once a complete bibliography is set up, the committee will be responsible for seeing that it is maintained. This bibliography is being prepared that we may proceed to work on those questions or problems which have already been solicited from the membership and which are awaiting some action.

(2) The committee has been contacted in regard to some prepared studies and notified about others which are already in progress. Information on these studies will be made available to the membership-at-large as soon as possible, through either the American Journal of Occupational Therapy, the Newsletter, the state liaison members, or all of these methods of contact.

In behalf of the committee I should like to say that, while we have barely been able to begin on our objectives, we hope that our continuing efforts will render a service to members of the Association.

Respectfully submitted,

Thelma Wellerson, O.T.R.
Florence M. Stattel, O.T.R.
Viola W. Svensson, O.T.R.
Helen L. Hopkins, O.T.R.
Winifred J. Watson, O.T.R.
Muriel E. Zimmerman, O.T.R.,
Chairman

THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

Previous reports on the activities of the Joint Commission on Mental Illness and Health have included information regarding the history of its origin and its plan of function. In a recent speech, Dr. Jack R. Ewalt, director of the Commission, stated that the Commission is "an expression of the deep-seated desire to do more for the mentally ill than has been done and to increase mental health in all people."

This succinct statement reflects the philosophy expressed at the preliminary meetings last year and since the Commission became official through legislative action in January, 1956.

The breadth of thinking which is encouraged by the Commission is reflected in the selection of a psychologist, Dr. Fillmore Sanford, and a sociologist, Dr. Gordon Blackwell, as assistants to Dr. Ewalt.

I submit for your information a listing of the studies sponsored by the Joint Commission. They are as follows:

The University of Michigan's Survey Research Center will carry a national opinion survey as one part of the Joint Commission's three-year study of the nation's mental health needs and resources. Several thousand persons from various regions of the United States will be interviewed in an effort to determine the extent of mental illnesses which are suffered by people who have not sought psychiatric care. A study of the means used by these people to solve their problems may bring new approaches to solutions sought by the committee in relation to mental health and treatment.

Dr. Morris Schwartz, a sociologist of note, heads another study concerned with what happens to the mentally ill in hospitals. This study is one of four that will investigate patterns of patient care for the Joint Commission.

A second group will concern itself with supporting agencies in the community, a third with mental health clinics and a fourth with rehabilitation.

Dr. William F. Soskin, a psychologist on leave from the University of Chicago, will direct a study of research operations. He will seek to see mental health research in its social, financial and intellectual environment. Its objective is to provide for the Commission a "document that can be of tangible utility to those who will be making the decisions about research in mental health."

Your representative has attended three meetings of this group since January; Mr. Manuel Brown represented the American Occupational Therapy Association at the Commission's annual meeting held in New York, September 29, 30. I also represented you at a special meeting devoted to "Mental Health Man-Power" held in Boston in July at which time representatives of the professional groups involved in the treatment of mental illness discussed in general terms the educational requirements, distribution of available personnel, and recruitment efforts.

Out of this conference has evolved a well formulated study which will extend over a period of 20 months. The conclusions reached by this study as well as others sponsored by the Commission will bring concise and useful information to the various professional groups who participate in this field.

It was good to be able to report on the American Occupational Therapy Association's recruitment program financed by the N.F.I.P. Another study sponsored by the American Occupational Therapy Association and financed by the National Institute of Mental Health was a subject of interest at this meeting. I speak of the psychiatric project sponsored by the National Institute of Mental Health.

I take this opportunity to thank my colleagues in the field of psychiatric occupational therapy who provided me with statistical information utilized at this "man power" meeting. This is one more example of spontaneous expression of helpfulness one so frequently experiences with O.T. colleagues.

It has been a privilege to represent you on the Commission and to be guided in further study and thought of a subject of many years of interest by highly respected authorities in the field of mental health.

Respectfully submitted,
Beatrice D. Wade, O.T.R.

LEGISLATION AND CIVIL SERVICE

Salaries for occupational therapists continue to be of interest in a number of areas. During the past year inquiries regarding salaries have been received from Ohio, Oklahoma, Texas, Massachusetts, Connecticut, and Illinois. In addition, it was called to the attention of this committee that California and Puerto Rico had similar interests. Also, classification of occupational therapists was of interest in Ohio, Oklahoma, Texas and Massachusetts.

The committee drafted and sent through the national office a letter to the American Hospital Association and U.S. Department of Labor expressing the Association's displeasure of the inappropriate job description appearing in a Government Printing Office publication, 1952. This followed as a result of the report submitted at the midyear meeting when the committee called it to the attention of the Board of Management.

A number of class specifications were reviewed to determine whether or not implications may exist in regard to non-professional personnel qualifying for the positions normally established for the registered occupational therapist. This report was submitted to the Board at the midyear meeting.

A letter outlining the purpose and function of the legislation and civil service committee was written and sent to the national office. This was done in conjunction with the special committee on standard operating procedures for standing committees.

A list of legislation and civil service references was compiled from the American Journal of Occupational Therapy, 1947 through 1955. This list includes all state and national association reports in addition to special articles relating to legislation and civil service.

The one major piece of work done by the committee was that of drafting three model class specifications for occupational therapy positions. The outlines were for: (1) staff occupational therapist, (2) senior occupational therapist, and (3) director of occupational therapy. In preparing the drafts the committee reviewed many class specifications in use throughout the country, and followed in general the terminology, format and content currently employed by most of the merit system and civil service offices. Further, the committee kept within the framework of the philosophy of occupational therapy. The models are planned as guides to assist civil service offices in writing new specifications or revising old ones. This, of course, could be done with consultation from local occupational therapy personnel, preferably the state association. With approval by the Board of Management it is hoped these model class specifications will soon be made available for distribution through the national office.

The committee feels that state associations might demonstrate more interest in legislation and civil service matters. The continued appointment of an active chairman in each of the associations may very well be a positive step in this direction. Locally, as well as at the national level, we cannot long remain in a state of inertia in any area if we desire to advance our professional standards, maintain a healthy and continued development, in addition to improving work situations and secure adequate remuneration for service rendered.

Respectfully submitted,

Helen Dahlstrom, O.T.R.
Thomas Crowe, O.T.R.
Evelyne Eichler, O.T.R.
Laurel Nelson, O.T.R.,
Chairman

PSYCHIATRIC PROJECT

At the Washington conference two years ago a committee was formed to request a grant from the National Institute for Mental Health. A project was formulated and a $24,000 grant was received as announced at the conference last year.

The project is now close to culmination. Ten commissions, strategically located in various parts of the country have come to grips with assigned problems concerned with the function and operation of occupational therapy with psychiatric patients. Their assignments include: (1) the use of group techniques in treatment, and in training, (2) evaluation of treatment media, and our relative preparation to use these media, (3) our role in bridging the gap between hospital and community, (4) our role within the hospital community, (5) our contribution to data for the evaluation and diagnosis of the patient, (6) our specific contribution in the realm of individual treatment, and (7) the communications by which our efforts are correlated or integrated with other professional efforts.

Each of these commissioners has prepared a report on its findings, and these reports have been sent to all of the persons invited to attend the conference. The reports have assumed monumental proportions. They are some five inches thick and provide a wealth of data on our strengths, our weaknesses, and our potential.

Two meetings of the commission chairmen have been held, and they have participated in the planning and selection of the people to attend the final conference. This will be held at the Allenberry Inn at Boiling Springs, Pennsylvania, November 13th to 19th, with attendance limited to some 60 invited participants. Each group will contain four occupational therapists from clinical field, three occupational therapists from educational field, two persons from allied fields of nursing, psychology, social work, rehabilitation or recreation, and one psychiatrist.

The topics for discussion cut across those of the commission studies. The first one is concerned with the techniques and procedures of all disciplines using activities with psychiatric patients. The topic will be discussed from one of the following angles by each of the discussion groups: (1) self as therapeutic tool, (2) group technique, (3) activities in bridging the gap between hospital and community, (4) activities in attaining specific treatment goals, (5) activities in contributing to psychodynamic formulations through personality, social and skill evaluation, (6) activities in creating a therapeutic milieu in the hospital.

The second topic is concerned with the definitive contributions of occupational therapy with reference to supportive milieu, supplementing psychotherapy, contributing to evaluation and socio-economic rehabilitation.

The third topic will consider to what extent the following should be a responsibility of occupational therapy and to what extent the occupational therapist is prepared to assume these responsibilities: (1) use of self, (2) group techniques, (3) music and drama, (4) recreation; library; and education, (5) creative or structured arts and crafts, (6) industry.

The fourth topic is concerned with the changes which are indicated in the academic and clinical preparation of the occupational therapist with reference to communication activities, current psychiatric developments, group techniques, the use of self, and integration of education and experience.

Summaries of the group discussions of each topic will be presented at plenary sessions, and these will be followed by general group discussion.

You will note that as the conference progresses, the emphasis is on education; this is in accordance with the terms of our grant. We do not, however, expect to come up with definitive answers, but rather hope to have a greater awareness of all that enters into the functioning of the psychiatric occupational therapist, and his education for that functioning, so that we may think more clearly in planning and developing clinical and academic preparation.

Elizabeth P. Ridgway, O.T.R.,
Chairman

PERMANENT CONFERENCE COMMITTEE

For the last few years the American Occupational Therapy Association has been anticipating this 39th annual conference with "Time for Reflection" in this beautiful "Land of Sky Blue Waters" here in Minnesota.

The Minnesota Occupational Therapy Association, ably directed by Miss A. Genevieve Anderson as local conference chairman, assisted by the co-chairman, Miss Dorothy Esch, has developed a conference program which is stimulating and of which we may be justly proud.

The institute, "What Constitutes Treatment," portrayed the pulse of occupational therapy, bringing to every therapist the vibrant purpose in her particular field of treatment endeavor. To Sister Jeanne Marie and her large committee we are deeply indebted for the graphic material in slides from which our whole membership may benefit through loan from our national office. Because of the educational scope of this institute project, Sister Jeanne Marie was able to obtain a grant from the Office of Vocational Rehabilitation to finance the production of the project. There are 350 registrations for the institute. This is very gratifying and indicates the interest of our membership in these institutes.

The conference program to which we look forward the rest of the week represents the careful planning of Miss Borghild Hansen as chairman, assisted by Winifred Johnson. Although time does not permit for individual acknowledgement, I am confident that you all wish to join me in extending grateful thanks to the many subcommittee members whose tireless efforts make our annual conference so fruitful and pleasant an experience. For nine months or more the local conference committees are doing yeoman volunteer service for occupational therapists everywhere. Perhaps you should realize that besides the institute and program committees there are local subcommittees for exhibits, hospitality, printing, publicity, registration, housing, special events including teas, AOTA party, school luncheon and banquet, special meetings and arrangements and transportation. This all adds up to a grand total of approximately 135 dedicated occupational therapists working for you and for me throughout the year to prepare and present the program you have before you.

The exhibits have much to offer you, educationally and practically. The educational exhibits are brought to us by professional, health and welfare organizations, and the military and Veterans' organizations at no cost to the American Occupational Therapy Association. I'm sure you will want to pay tribute to their mutual interest and cooperation with occupational therapy by carefully viewing every exhibit. You will find a wealth of educational material of value in your various fields of interest.

The commercial exhibits include many of our old friends whose products, service and loyalty we value highly. Also there are goodly numbers of new exhibits, with a wide variety of supplies, equipment and appliances to show you. It is important that you manage adequate time to thoroughly examine each display, to meet and visit with the representatives. Many of them are advertisers in the American Journal of Occupational Therapy and Yearbook. We are their clients, their services are valuable to occupational therapy. Be careful to mention the importance of their product and that you have seen them in AJOT or the Yearbook.

Most of you will remember the necessity of getting your punch cards for the commercial exhibits completed and deposited in the box before the commercial exhibitors' party on Thursday evening preceding the banquet. You will find the punch cards in your conference packet. These prizes are donated by the commercial exhibitors and the drawing is a source of anticipation and fun at the party, so let everyone join in by visiting every exhibit. The exhibit representatives are anxious to meet and to serve you.

Of significant importance this year are the field trips in which we hope many of you will participate. It is a rare opportunity to visit the Mayo Clinic. One of the highlights of the last AOTA conference here in the Nicollet in 1927 was a trip afterward to the Mayo Clinic. I need not remind you, with the progress in occupational therapy in the intervening years, how much more of value this field trip holds for all of us.

The 1957 conference will be held at the Carter Hotel, Cleveland, Ohio, October 19 to 25. The local general chairman is Miss Mildred Schwagmeyer of Columbus, Ohio, who is well known to many of us. There is consideration of presenting the workshop type of program at the Cleveland conference. This suggestion has been projected by our membership. It requires extensive planning and would necessarily encompass several of the treatment specialties. Perhaps the conference time could be allotted partly to the workshops and partly to special program presentations in the areas not covered in workshop sessions. The permanent conference committee welcomes your reactions, your suggestions and ideas.

Please use the suggestion box in the registration area. Forms are provided for your comments and suggestions. Your thoughts can help us to better direct the function of the committee toward planning and arranging the kind of conference program that you prefer.

By approval of the Board of Management at its midyear meeting held at Detroit, Michigan, in April, a cochairman of the permanent conference committee was appointed in the person of Mr. Laurel V. Nelson, O.T.R., who is a consultant for rehabilitation therapies of the division of medical services of the Minnesota department of public welfare. Mr. Nelson joins me on behalf of our national office in thanking the Minnesota Association for the very efficient operation of this meeting.

Respectfully submitted,

Winifred C. Kahmann, O.T.R.
Chairman
Laurel V. Nelson, O.T.R.
Co-Chairman

COMMITTEE ON RECOGNITIONS

Just how important is an award—a recognition? It is a most important means of stimulating interest in the development of improved methods and techniques in any profession. It is an important aid in promoting research, education, public relations, recruitment and administrative accomplishments.

In 1955 the committee on recognitions was established as a standing committee to act as a clearing house for all contemplated awards proposed by any group or individual member of our Association.

In August of this year a complete report of the committee on recognitions was sent to every member of the American Occupational Therapy Association. This report included a copy of the standing operating procedures for nomination and selection of candidates for the Eleanor Clark Slagle lectureship and the Award of Merit. The committee felt that such information would acquaint each member with the eligibility requirements for nominations for these awards, and arouse interest in making known the work being done by their fellow associates.

The Eleanor Clark Slagle lectureship, which is an academic award for unusual accomplishment in the field of occupational therapy, was established in 1955 in memory of one of our outstanding pioneers. Last year Miss Florence Stattel, O.T.R., was the first lecturer selected for this honor. This year the lectureship has been awarded to Miss June Sokolov, O.T.R.

The highest honor of the American Occupational Therapy Association, the Award of Merit, has been given to seven occupational therapists during the past six years.

Mrs. Eva Otto Munzesheimer, 1950
Miss Wilma West and Mrs. John A. Greene, 1951
Mrs. Winifred C. Kahmann, 1952

In 1953 no award was made.
Misses Helen Willard and Marjorie Taylor, 1954
Miss Henrietta McNary, 1955.

The present study under consideration by our committee is the establishment of a suitable recognition for retiring registered occupational therapists with an unusual service record.

Respectfully submitted,
Mary Britton, O.T.R.
Caroline Thompson, O.T.R.
Gertrude J. Murray, Capt., AMSC
Chairman.

PUBLIC INFORMATION

The office of public information (or recruitment and publicity as it was previously called) was reactivated on May 21, 1956, after a hiatus of six months. A continuing grant from the National Foundation for Infantile Paralysis has made this possible.

Mailings of career literature. In addition to orientation, the director of public information spent the first month in cleaning up a backlog of requests for career literature which had resulted from lack of personnel in the public relations office. Since that time, mailings have gone out on almost a daily basis. As of August 31, 1956, this division has sent out literature to an additional 985 persons. The total number of pieces mailed out is 12,980.

The following new or revised mailing pieces have been produced:

1. Occupational therapy fact sheet (revised)
2. Schools list (revised in easier-to-mail size with less pages)
3. Thank-you card enclosure for inquiries printed in blue ink with OT insignia (new)
4. Reprint of column by Dr. Howard Rusk in *New York Times*, February 26, 1956, calling attention to need for rehabilitation personnel including occupational therapists. Sent to guidance counselors and librarians only (new).

Contacts with state recruitment chairmen. Contacts have been re-established with recruitment chairmen in 43 states, including unchartered states. A few states have not yet appointed their 1956-57 recruitment chairmen and in a few small state associations, the presidents are serving in a dual capacity. In addition, O.T.R.'s have been enlisted to do recruitment in three states previously untouched: Alabama, New Mexico and Wyoming. To date, two letters have been sent to the recruitment chairmen including enclosures of lists of prospective students and guidance counselors, broken down by states. These lists will be sent to recruitment chairmen monthly or bimonthly. Recruitment chairmen also received materials prepared by the National Health Council on their Health Careers Project; a reprint of an article from March 16, 1956, *Hospitals*, "Rehabilitation—a Patient's Viewpoint," as help in gathering material for a talk on OT; copies of the revised OT fact sheet and schools list; and copies of "Mobilization and Health Manpower," a report of the health resources advisory committee on paramedical personnel in rehabilitation and care of the chronically ill, which contains a section on occupational therapy.

Contacts with school directors. School directors have received copies of prospective student and vocational guidance lists prepared to date, with memos suggesting how to best make use of these materials. They have been advised of the forthcoming project of sending hometown releases on students who have passed the registration examination. (See "Newspaper Stories.")

Literature distribution (other than usual mail channels). Career literature on occupational therapy will be distributed this fall at three fairs: the New York state fair, Missouri state fair and the Dutchess County, N. Y., fair.

We have sent career literature to women's auxiliaries of the American Medical Association for inclusion in health careers kits being distributed to high schools; to the Catholic Hospital Association for a source of listing for hospital administrators; to institutes and workshops for rehabilitation personnel at Arizona State College, the University of Oregon and the University of Oklahoma; to Indiana University for use in package libraries that are loaned to the people of the state; to the field relations counselor at the University of Wyoming for distribution to the high schools of the state; to several health careers committees, and many other groups.

Newspaper stories. While the annual conferences of AOTA have always gotten excellent coverage in the city and state where they were being held, they have not received much space in the press outside these areas. The director of public information is working closely with the publicity committee for the conference in preparing news releases for the newspapers and press associations in New York, to supplement their efforts with the Minneapolis and Minnesota press. In addition, a release was prepared for 35 publications of allied professional organizations with an enclosure of the preliminary program of the conference. A hometown release form has been prepared to be used by all O.T.R.'s attending the conference. This is being mailed out with the September Newsletter. Fill-in releases will be sent out to hometown newspapers of those who pass the June registration examination.

The public relations department of United Cerebral Palsy has cooperated with us by sending out hometown releases on students who were recipients of scholarships given under their yearly $10,000 scholarship grant to AOTA. In addition, a 3-page feature story tying in the angle of their scholarship grants with the need for occupational therapists in the treatment of the cerebral palsied has been distributed to all their affiliates.

Magazine contacts. Material was prepared for the career editor of *Mademoiselle* on opportunities for American occupational therapists to work abroad. The project involved detailed research on job responsibilities of O.T.R.'s who have worked or are now working in foreign countries, and included information on the Armed Forces. An interview with another member of the school and career department of *Mademoiselle* about the scope of the profession and educational requirements may result in an additional story.

Facts and figures about the profession and its shortages were given to a writer for *Parade*, a syndicated Sunday picture supplement for 57 newspapers, who is doing a series of articles on mental hospitals and how shortages of personnel affect treatment and discharge rates.

Other publications. Career literature to be used in preparing material on OT for a publication exploring the major professions was sent to Barron's Educational Series, well-known publishers of secondary school examination outline series. They will submit copy for checking.

Copy on "What Is Occupational Therapy" and pictures have been submitted for an encyclopedia to be sold in supermarkets, published by Book Service America, Inc.

A 250-word statement on occupational therapy is being prepared for United Cerebral Palsy of New York State for inclusion in a brochure on careers in the health field that aid the cerebral palsied. It will be distributed to guidance counselors and students in the state.

Recruitment and publicity news has appeared in every issue of the AOTA Newsletter.

Recruitment film. At this writing, a draft of the proposed script for the film written by the producer, Mr. Erik Cripps, is being considered. After members of the professional staff have made their comments, the thought is to seek the opinions of an advisory group, including O.T.R.'s, vocational guidance personnel, perhaps a prospective student, and a student therapist. The script was prepared by Mr. Cripps after many "briefing" sessions with the professional staff, by an all-day orientation field trip to occupational therapy departments in five hospitals in New York City, by a conference in the national office with 17 occupational therapy students from four colleges, who were on clinical affiliation in New York. The purpose of this conference was to discuss the aspects of occupational therapy that would be the most appealing to young men and women. The observations of these students not only were extremely helpful to our producer but also have given the director of public information a fresh perspective on the preparation of future recruitment literature. The script seems to be shaping up as a black and white motion picture. The budget will not permit consideration of a color movie.

New literature. A new publications and materials list came off the press September 5. An 8-page folder in dark green ink on off-white stock takes the place of the previously mimeographed list. Descriptions of most items, particularly the professional manuals and technical reprints, and the use of bold face type for titles and their prices gives the new list a professional and business-like look. The list includes career literature and visual aids for recruitment as well as professional publications.

Correspondence of interest. The director of public information and education of the Pennsylvania department of welfare has been contacted about including information on the shortage of occupational therapists in news stories on their intensive recruitment campaign for personnel for state hospitals and schools. He requested statistics and background information.

Your director of public information has been in touch with Mrs. Alice K. Leopold, assistant to the Secretary of Labor for Women's Affairs, regarding the possibility of revising leaflets and bulletins on occupational therapy published by the Department of Labor because the material is out of date. She wrote that the Department of Labor is currently revising the Occupational Outlook Handbook which will include up-to-date information about OT.

Meetings attended. The director of public information attended the annual meeting of the New York State Occupational Therapy Association, May 26, 1956, White Plains, N. Y. Among other meetings at which she has represented the Association are: the health education committee of the National Health Council and the allied medical professions career information committee, composed of representatives of OT, PT, and dietetics in the New York area, sparked by Capt. Gertrude Murray, AMSC (OT).

Future planning. Our greatest immediate need is more attractive career literature, with pictures. Eye-appeal is important today in "selling" whether a profession or product is being marketed. More attractive career materials would spur our own members on to greater recruitment efforts. Projected plans include:

1. Preparation of a photo-offset picture brochure using text from the Health Careers Guidebook. Press proofs on the text have been made available to us by the National Health Council.

2. Elimination of "How to Become an Occupational Therapist." It is redundant, duplicates information in other pamphlets.

3. Reprinting good newspaper stories about OT: inexpensive and effective literature.

4. Encouraging state associations to develop own literature.

5. More exhibit materials; develop or locate specialized exhibits, refurbish two small AOTA exhibits, encourage state associations to develop own.

6. Newspaper and magazine stories on national level; more feature stories on local level.

7. Expansion of recruitment contacts with guidance groups, junior colleges, state and local health careers committees, PTA's, "Y" groups, art and science teachers, Boy and Girl Scouts.

Respectfully submitted,

Rheta B. Glueck
Director

RECRUITMENT COMMITTEE

With the addition of Miss Rheta Glueck to the AOTA staff, the recruitment program is being reactivated. Recruitment reports have been received from sixteen states, and have pointed up the use of radio, television, hospital visits and speakers' bureaus with varying degrees of success. As it has not been possible to gather any statistics, the effectiveness of career days has been hard to determine. Some states have designed literature and small gadgets to supplement material sent from the national office. There is an increasing need for more of this to be used on the local level. Among the outstanding projects that have brought tangible results has been a Girl Scout merit program and a course organized for high school seniors, to equip them to act as volunteer aides. Some occupational therapy departments have given small teas for students who have expressed interest in occupational therapy. It has been generally felt that personal contact by an informed and enthusiastic therapist, however, has been the most persuasive method of recruitment.

At the meeting in Minneapolis, consideration was given the area organization plan adopted in 1955, and it was voted that this be dropped as it has proven to be too unwieldy and did not offer the desired results after a year's trial. Subsequently, a program for future planning was structured which included the following suggestions:

(1) A monthly newsletter which will take the place of the former bulletin will be sent jointly from Miss Glueck and the national recruitment chairman to state chairmen. This will contain a condensation of quarterly reports sent from the latter, and will be the means of disseminating pertinent information which will aid those needing assistance with their programs.

(2) A questionnaire will be sent to state chairmen and OT schools, soliciting information relative to their needs. Closer contact with the schools is planned in order to obtain statistics which can point up the success or failure of the recruitment effort.

It is desired that there be better integration of the program and it is hoped that with the cooperation of the state committees, guide lines will be set that will aid the director of public information in planning a vital and dynamic recruitment campaign.

The quota for 1957 has been set and a slogan determined: "One recruit from every registered occupational therapist."

Respectfully submitted,
Frances L. Shuff, O.T.R.
National Recruitment Chairman

REGISTRATION COMMITTEE

"The AOTA Registration Examination: Past, Present and Future (A 10-Year Progress Report") by Hyman Brandt, Ph.D., AOTA educational research consultant, will be published in the November-December, 1956, issue of AJOT. The history of the examination, as recorded in this article, is one of which the Association may be proud. Since this article covers the activity of AOTA relative to the registration examination, only those data not included will be summarized in the following report.

Membership and function of registration committee. Over the past ten years, the registration committee has had a total of twenty-five active members. In addition to these members, two AOTA executive directors, four educational secretaries, the new assistant in the education office and the educational research consultant have been actively engaged in the work of this committee.

At the present time, the committee is composed of ten active members and seven consultant members (all of whom have served as active members in the past). Five of the currently active members have joined the committee within the past year. Members of this committee are experts in the various subject matter areas covered by the examination. Wherever possible, attempts are made to secure members who are graduates of different schools of occupational therapy. In the past, financial limitations have of necessity caused the committee membership to be drawn from one geographical locality. Recently, it has been made possible for the active membership to be broadened somewhat in this respect. The consultant members now give us an even greater geographical coverage.

With the initiating, this year, of the new operating procedures for the registration committee, its primary functions are briefly stated as follows:

1. Maintenance of the examination
   a. Review of statistical data subsequent to each test administration with decisions as to retention, revision or deletion and replacement of items (in scheduled meetings).
   b. Review, editing and acceptance of new items submitted by the writers for the replacement pool (by mail).
2. Policy recommendations and decisions (in scheduled meetings.
3. Further development of and research relative to the examination (in scheduled meetings).

June, 1956, registration examination. The examination was administered on June 29, 1956, to 297 examinees as follows: 294 from 27 schools approved by the AMA; one graduate each from the Danish School of OT; Sydney OT Training School in Australia; University of Toronto in Canada.

In addition to 25 schools of occupational therapy, this examination was proctored at the following institutions: University of Arkansas in Fayetteville; Athens College in Alabama; Brigham Young University in Utah; University of Hawaii in Honolulu; University of New Brunswick in Frederickton, Canada; Oregon State College in Corvallis; University of Oregon in Eugene; University of Toronto in Canada; University of Western Australia in Nedlands.

Date	No. Examinees	Part I Mean	Part I Sigma	Part II Mean	Part II Sigma	Total Mean	Total Sigma	Correlation of Parts I & II
Feb. 1947	161	95.1	11.1	89.4	11.1	185.0	20.0	+ .78
June 1947	143	89.5	12.3	90.0	11.3	179.5	22.3	.81
Feb. 1948	240	90.1	12.6	84.9	11.5	175.0	22.4	.74
June 1948	265	92.6	12.3	90.3	13.2	182.4	24.4	.78
Feb. 1949	195	94.8	12.8	84.9	12.7	179.3	23.8	.76
June 1949	163	95.8	11.7	94.9	11.8	190.7	22.5	.80
Feb. 1950	186	84.3	10.7	94.3	12.0	178.2	21.0	.69
June 1950	204	83.7	12.0	87.3	13.6	170.2	24.3	.79
Feb. 1951	203	92.1	13.2	87.2	12.4	179.3	24.2	.80
June 1951	235	90.5	12.5	89.0	11.6	179.2	22.8	.79
Feb. 1952	204	91.3	12.5	92.3	12.8	183.3	23.4	.81
June 1952	265	89.6	12.1	93.9	13.0	182.9	23.9	.71
Feb. 1953	240	90.0	13.3	87.6	13.1	175.4	25.5	.85
June 1953	214	88.7	13.0	88.6	12.1	176.1	24.9	.86
Feb. 1954	243	89.8	13.9	89.7	13.9	179.5	26.5	.80
June 1954	284	85.6	14.8	85.1	14.7	170.0	28.1	.84
Feb. 1955	270(240)	86.2	15.0	87.4	14.7	175.4	28.3	.83
June 1955	332(312)	87.3	14.2	87.7	14.9	176.4	26.2	.84
Feb. 1956	223(199)	90.5	13.6	89.8	13.5	176.9	26.7	.85
June 1956	297(265)	93.2	13.8	91.8	15.4	184.6	28.6	.86

*Table I**

Comparative Data. The AOTA registration examination has been administered twenty times in the past ten years to approximately 4,600 students. Approximately 250 of these have retaken the exam one or more times. The data obtained, including June, 1956, have been listed in Table I.

Examination of the data relative to the written phase reveals the excellent stability of the examination. In the original planning, a score of 180 was projected as a desirable mean score to achieve the best possible spread of scores on the examination. With but three exceptions (170 in June, 1950 and 1954, and 190 in June, 1949) the average score has been plus or minus five points above or below the mean value of 180.

The statistical measure depicting this spread (sigma) has also been very consistent and has again hovered within five points above and below our projected value of 250. This value gives a range of scores (projected) from 105 to 255. There have been very few scores below the former and above the latter. As a matter of fact, each of these distributions have approximated the normal distribution curve so closely that the percent of students achieving a given score is almost identical with the per-

*The data for the evaluation of performance in student affiliations are omitted since three different types of report forms containing three different systems of scoring have been used during this ten year period.

cent cut off by sigma units of the normal probability curve.

While the data for the student affiliation evaluations are not reported, their contribution weighted at 20% has not affected the shape of the distribution curve. The results obtained for the total converted scores are equally stable and consistent. The variation in mean score has been approximately three points and only twice has the mean converted score risen to 64 or above. The measure of spread has behaved just as consistently. These have permitted the accurate reporting of results to the schools in terms of decile and quartile scores.

As can be expected from such data, the relationship of the two parts has also been consistently high. The correlations have varied between eight points above and below the projected value of +.78. Thus one part is not duplicative of the other but suggests rather that the student is being effecively measured on each part of the exam.

all of their affiliations, distributions were drawn of RPSA scores in the five major disability areas. The data given below show a two-point spread in average score above and below the overall mean (158.4). At the present time, this variation is not significant and could well be a reflection of differences in student performance as related to the order (1st, 2nd, etc.) of their affiliation assignment. The following data gives a breakdown by disability area for the June, 1956, RPSA's.

	No. RPSA's	Mean	Sigma
Psychiatry	249	160.4	31.8
Physical disabilities	263	157.0	32.7
Pediatrics	226	158.5	31.3
Tuberculosis	182	159.8	31.7
General medicine, surgery	184	155.9	34.0

The major study involving considerations of disability area and order of affiliation as they are reflected in

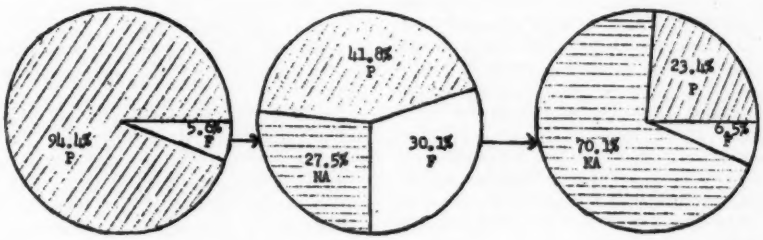

*Table II**

The actual converted score chosen as the cut-off point to differentiate passing from failure has been arrived at after each test administration. It has been decided solely upon the basis of that particular distribution. As the data suggest, there has been (with one exception of 55.0 in June, 1949) but a two point variation about a projected value of 51.5 which would eliminate approximately 7% of the students each time. This value (7%) is a point which corresponds to 1½ sigma below the mean on the normal curve. It is the point halfway between the bottom and the mean on the lower half of the curve. The failure rate on the AOTA registration examination has been fairly uniform, the range being from 5 to 7% with an overall average (for 20 exams) of 5.6%.

Report of Performance in Student Affiliations (RPSA). In June, 1956, the student affiliation reports were overwhelmingly RPSA. The few CTR scores were, therefore, converted to RPSA scores. The resulting RPSA distribution was converted to a 20% basis for inclusion in the total registration examination score. The same conversion tables developed for the February, 1956, examination were used.

Examination of the following data reveals that this procedure was in order. Although the RPSA scores show a slight rise (5 points) in average score, the spread of scores remained esesntially the same.

RE Date	No. RPSAs	Mean	Sigma
Feb. 1956	732	153.5	31.9
June 1956	1,104	158.4	32.3

Since there were many students whose performance had been evaluated (for the first time) on RPSA's in

variation in RPSA scores has not been completed. The education office has not received a sufficient number of RPSA's for students assigned to a tuberculosis center for their fifth affiliation. As soon as these reports are received, a complete report will be prepared on this study.

Spanish Translation of the Registration Examination for graduates of Puerto Rican School. The examination was first administered to seven graduates of this school in English in February, 1955. A Spanish translation was administered to six graduates in April, 1956. Analyses of the percentage of error were prepared for the examinees on both of these examinations.

The data from these analyses indicate that there was little advantage in giving a Spanish translation to graduates of the Puerto Rican school. The registration committee therefore recommends to the Board that the graduates of this school be required to take the registration examination in English and that examinees from this school be held to the policy of only three attempts at the examination regardless of the language in which it was administered.

Failures. The overall percentage of failure for examinees taking the examination for the first time is 5.6%. The scores of these students have been so low as to indicate that they have neither assimilated nor have they been able to successfully utilize the information and skills which they have been taught. To substantiate this belief, a further study was made of the number of retakes and their relative success when attempting the exam a second or third time (see Tablie II).

*P=passing; F=failing; NA=No attempt.

It was found that those who retake the examination have a little better than a 50-50 chance of passing it. On the other hand, those retakes who come back for their last attempt (after failing twice) come through on almost a 4 to 1 basis. These data suggest that those who do make a last attempt probably do not do so until they have tried to prepare themselves as adequately as they possibly can for the examination. No point can be made of the non-attempts of failures since the 1956 results are included in the data and there has been very little opportunity for retake of the February, 1956, and no opportunity for the June, 1956, examination.

Dates for Administering the Registration Examination. The 29 approved schools were surveyed relative to the average number of students completing clinical affiliations each month. This survey was undertaken following the February, 1956, examination since 72 of the examinees did not complete their clinical assignments until one month after taking the examination. This percentage of "late finishers" was high and occasioned further delay in reporting the results of the examination.

The data from the survey indicated that a shift in date of administering this examination was possible without unduly penalizing any graduate. The registration committee therefore recommends that the examination be administered the last Friday of January, instead of February, beginning in 1958. Reaction to this recommended change is being sought from the schools at the 1956 annual conference.

Fees for Examination Taken Overseas. Examinations administered overseas or in outlying possessions of the United States must be forwarded via first-class registered airmail whereas those given in the United States are sent via first-class certified surface mail.

Since these postal rates are much higher, the registration committee recommends to the Board a surcharge of $5.00 be made, in addition to the regular examination fee, for all examinees taking the examination in foreign countries, with the exception of Canada. It is further recommended that in the future, should the regular fee be increased, this surcharge be maintained.

Drive for Registration Examination Items. With the assistance of Mrs. Wanda M. Edgerton, O.T.R., a concerted effort has been made in the past year to procure a pool of 600 to 1,000 items for the examination.

Although efforts have been made, when contacting potential item-writers, to secure a representative coverage of graduates from all of the schools as well as therapists practicing in the various geographical areas of the country, our results have not been satisfactory. Over the past ten years graduates of 22 schools have contributed items, but only nine of the schools are represented by five or more writers. During the same period, therapists practicing in 28 states and Hawaii have written questions; however, in only nine of these have there been five or more contributors.

In addition to the direct correspondence with potential item-writers, other avenues of approach have been or are being followed, including:

1. Request for assistance from directors of schools.
2. Publication of an article "A Call for Volunteers" in the September-October issue of AJOT.
3. Publication of Dr. Brandt's feature article on the registration examination in the November-December, 1956, issue of AJOT.
4. Conduct of a workshop session in item-writing in conjunction with the 1956 annual conference.

From the results of the current item drive to date, it does not appear that the direct correspondence method and the token payment for acceptable items are going to meet the current need for items. This need is at present critical for replacement alone.

It is recommended that the Board of Management give approval for conducting three to four more such workshop sessions on a regional basis. The cost for holding these sessions would, in part, be offset by decreasing the follow-up correspondence currently being carried on in the education office and decreasing the consultant's time in reviewing items relative to proper test construction.

Medical Approval of Examination Questions. The AOTA medical advisory council is being consulted as to possible methods for obtaining medical approval for all of the disease entity items submitted for the examination.

In the interim, as a temporary measure, we are asking the committee reviewers to seek approval of items assigned to them from physicians with whom they work.

Sample Registration Examination Questions. A new set of sample questions has been prepared and duplicated for distribution as indicated. The primary objective in preparing this sample set is solely to illustrate the variety of ways in which multiple-choice questions can be and are used in the examination. Questions selected for this set have been used and retired from past administrations of the examination. The excellent variety of multiple-choice appearing in the examination is well illustrated by the 26 different types of questions selected for this sample set.

Copies of this set of questions will be supplied as illustrative material to all item-writers. They will also be available to occupational therapy schools and international reciprocity applicants to acquaint examinees with the format of the questions used in the examination.

Removal of Questions on Treatment Media From Registration Examination. Due to other commitments the proposal has not been written in regard to securing financial assistance for undertaking the removal of these questions from the examination and the setting up of a different method of evaluating this phase of a student's knowledge. This proposed project has, therefore, been referred to the AOTA development committee.

Examinees Under International Reciprocity. Since 1953, graduates from the following foreign occupational therapy schools have taken the AOTA registration examination.

Australia, OT Training Center, Sydney	2
Canada, University of Toronto	9
Denmark, Skolen for Beskaeftigelsesterapenter, Hellerup	1
England, Dorset House School of OT, Oxford	1
Liverpool School of OT, Huyton	1
OT Centre and Training School, London	3
St. Loyes School of OT	1
Scotland, Astley-Ainslie Hospital, Edinburgh	2
Total	20

Within the past year, inquiries have been received from approximately 15 graduates of foreign schools relative to their taking the examination. In addition, it has been requested that consideration be given to the eligibility of graduates of the Burgerspital Basil OT course in Switzerland to take the examination. The committee is awaiting further information relative to this curriculum prior to taking action on this request.

Registration Examination Prospectus. The maintenance and/or changes in our educational standards and their appraisal by means of the registration procedure will require future concentration in several directions. A few of these considerations are included in the following:

1. As the findings and deliberations of curriculum surveys and institute workshops are translated into changes

in emphasis and newer curriculum content, it will be necessary for the registration committee to review the item content and area allocation of the registration examination. This will insure the appropriate reflection of the current school curriculum in the content of the examination.

2. To best maintain and improve the present level of item effectiveness in the registration examination, a large pool of items, suitably representative of all areas of occupational therapy, must be made available to the registration committee.

3. Prior to reconsidering an adjustment between the weighting of the written examination and the clinical affiliation phase of the registration procedure, the behavior of the RPSA must be thoroughly reviewed.

4. To effect the removal of items on media techniques from the examination, other methods of evaluating this phase must be developed.

5. In order to introduce other types of objective test items into the examination, such as those presenting situations requiring the student's judgment and application of knowledge in resolving problems, a careful analysis will have to be made to insure securing situations which are standard, comprehensive and non-controversial.

6. With ten years' data on the registration examination now available it would be well for us to again consider a critical study of these results as related to:

a. Academic grades of students

b. Clinical affiliation scores

c. Student's achievement on mental ability measures administered by schools.

Deep and sincere appreciation is extended to all occupational therapists who have worked so unfailingly in developing and maintaining the registration examination.

Respectfully submitted,

Mary Frances Heermans, O.T.R.
Chairman.

* * * *

TEACHING FELLOWSHIPS

The National Foundation for Infantile Paralysis announces the availability of teaching fellowships for occupational therapists to prepare for academic and administrative positions in schools offering approved curricula in occupational therapy.

Application may be made to the National Foundation at any time during the year but awards are made following each meeting of the Clinical Fellowships Committee May 1, November 1, and February 1. Applications must be filed two months before the meeting of the committee (i.e. March 1, September 1 or December 1) and must be made prior to the start of the applicant's education program.

An applicant is required to be: in good health as evidenced by a recent physical examination; a citizen of the United States or to have filed a petition for naturalization. He must have a baccalaureate degree and present significant and satisfactory general experience as an occupational therapist for three years or more. Candidates without this experience will be considered if they are nominated by a school offering an approved curriculum in occupational therapy.

Fellowships are awarded for periods of one to three years. Those applicants without three years of experience must present a program of study for a minimum of two years.

Financial benefits range from $200 to $350 per month depending on previous education and experience. Partial fellowships are available to supplement G.I. educational benefits. Compensation is made to the institution for complete tuition and fees if a full academic program is pursued. When the program involves other than academic training, compensation up to $1,250 a year, including tuition is paid.

Dr. Catherine Worthingham, left, director of the division of professional education, National Foundation for Infantile Paralysis, and Miss Marjorie Fish, executive director of the American Occupational Therapy Association, discuss the best means of notifying qualified OT's of the availability of NFIP occupational therapy teaching fellowships. 1957 *application deadlines are March* 1 *and September* 1.

In the associate medical fields in addition to teaching fellowships for occupational therapists, awards are made to prepare physical therapists for teaching positions and scholarships are offered for the basic preparation of physical therapists and medical social workers.

Teaching fellowships for occupational therapists are a part of the National Foundation's professional education program which includes postdoctoral fellowships in the fields of research, psychiatry, rehabilitation, the management of poliomyelitis, orthopedics, and preventive medicine. Short fellowships for medical student vacation time study are also included.

The National Foundation has authorized the expenditure of $24,900,000 since 1938 for scholarships and fellowships and for aid to educational institutions, professional organizations, and related activities.

For further information and application blanks, write to:

Division of Professional Education
National Foundation for Infantile Paralysis
120 Broadway, New York 5, N. Y.
(after March 1, 1957, address all correspondence to NFIP at 301 East 42nd Street, New York 17, N. Y.)

The Philadelphia School of Occupational Therapy will offer a special course of study to provide additional information in specialized areas. The courses are sponsored by a grant from the United States Office of Vocational Rehabilitation.

February 11-22
Organization, Administration and Supervision

* * * * *

March 11-22
Neurological Bases for Rehabilitation

* * * * *

April 22-26 and June 17-21
Principles of Rehabilitation

For further information write:
Miss Mildred L. Wood
General Laboratories Bldg.
University of Pennsylvania
215 South 34th Street
Philadelphia 4, Pennsylvania

DELEGATES DIVISION

GEORGIA

Delegate-Reporter, Martha Schnebly, O.T.R.

1955-56 saw G.O.T.A. struggling on through the difficulties of a changing membership. Although it grew to the grand total of 40, more than fifty per cent moved into the state or out of the state in the twelve months. Due to this large transient personnel, we have been able to benefit from the knowledge and advice of some excellent therapists, but so frequently their stay is too brief to carry through the splendid projects they so enthusiastically proposed.

In spite of our difficulties we have been able to attend four program meetings, two of which were held jointly with the state chapter of the American Physical Therapy Association.

The Newsletter of G.O.T.A. has completed a successful year under the editorship of Mrs. Virginia Bergamo. This paper has served to inform the membership of the activities in the state, especially actions taken at the meetings because distances from center to center limit the first hand contact of members. It is a valuable asset for the organization.

In addition to recruiting students for the occupational therapy schools, the membership has had to work hard on recruiting practicing therapists for a number of positions. There is a growing interest in this state in OT and we feel that we have a real responsibility to assist in locating therapists while the interest is here.

OFFICERS

President .....Nina Crawford, O.T.R.
Vice-president .....Margaret McGregor, O.T.R.
Secretary-treasurer .....Mrs. Helen H. Flaherty, O.T.R.
Delegate .....Martha Schnebly, O.T.R.
Alternate delegate .....Muriel Driver, O.T.R.

INDIANA

Delegate-reporter, Ruth Grummon, O.T.R.

The Indiana Occupational Therapy Association has attempted to give special attention in 1956 to increasing membership as well as attendance in the association. Until this past year we considered ourselves to be among the smaller organizations; however, we have now grown to 46 active and 12 associate members.

Much of this increase has come from members in the northern part of the state who are now in the process of forming the Northern District. Already several meetings have been held, one of which, at the Marion VA Hospital, had an attendance of about 50 persons at a luncheon and more than 100 for the program which followed. Interest is running high with this group and we expect great things of them. The present plan is for two state meetings and six to eight separate meetings each year. However, members are encouraged to attend meetings with both groups.

With the increase in membership greater emphasis has been placed on providing time at each meeting for a social hour which includes refreshments. Another innovation was a Christmas party.

Recognizing that an interested membership is an actively participating one, a very real effort was made to have every member really working on at least one standing committee. For the first time a complete state directory was given to all members and prospective members.

Following our custom of recent years we have continued to have a January joint meeting with the physical therapists and a spring meeting with the Kentucky Occupational Therapy Association. At the January meeting we were fortunate to have a group from Goodwill Industries present their work in a vocational rehabilitation evaluation program which is receiving national notice.

In September an all day state meeting was held at the newly dedicated Crossroads Rehabilitation Center. The business meeting and luncheon were followed by the presentation of the blind adjustment program carried on by Crossroads in cooperation with The Industrial Aid for the Blind. Presentations were made by the therapist in charge and a member of the staff of The Industrial Aid for the Blind. At the request of many members, the October meeting, with the delegate reporting on conference, included a discussion by several members on the structure and function of the many committees of the American Occupational Therapy Association.

Our recruitment program has been carried out by the chairman and her committee. A number of talks were made over the entire state and literature was placed in each high school and college in the state. It is impossible to know the exact results of this work but it is felt it should be more apparent in a few years since in September, 1956, Indiana University established courses in occupational therapy and physical therapy. The first two years will be spent on the Bloomington campus, the rest on the Medical Center Campus in Indianapolis. Such a course has long been desired by Indiana therapists and its development will be followed with interest.

We are especially proud to report that one-third of the active members attended the annual conference in Minneapolis.

OFFICERS

President .....Miss Edna Faeser, O.T.R.
Vice-president .....Miss Mary Sahs, O.T.R.
Secretary .....Miss Mary Lou Godette, O.T.R.
Treasurer .....Miss Elaine Bates, O.T.R.
Delegate .....Miss Ruth Grummon, O.T.R.
Alternate-delegate.... .....Miss Wilma Franz, O.T.R.

MINNESOTA

Delegate-Reporter, Mary Van Gorden, O.T.R.

Paul Bunyan has once again headed for his home in the north woods, and members of the Minnesota Occupational Therapy Association are gradually settling back into the old routine after having spent a busy year and one-half staging and producing the 39th annual American Occupational Therapy conference . . . Our "Time for Reflection" has finally arrived.

Much of the "settling back process" is being done with a sigh of relief; however, a certain amount of reluctance is involved, for preparing for the conference was, without a doubt, a most stimulating and rewarding experience. Although conference preparations entailed months of hard and, often, tedious work, satisfactions gained by MOTA members are too numerous to list. Memories of those busy months will long be cherished.

In addition to personal satisfactions achieved through producing the conference, the Minnesota Occupational Therapy Association, itself, received an impetus which would be difficult to reproduce. During the past year, membership in the Association doubled, and unity and enthusiasm among members increased to an all-time high. Unknown talents and aptitudes were discovered and were put to work. With such resources at hand, MOTA

should not find it difficult to make 1957 another highly successful year.

OHIO, our best wishes are extended to all of you. May 1957 prove to be as wonderful a year for you as the past year was for each of us.

OFFICERS

President .....Evelyne Eichler, O.T.R.
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WASHINGTON

Delegate-Reporter, Pauline C. Arvesen.

The Washington Occupational Therapy Association has thirty-eight active members and eight associate members. The Association raised funds through ticket sales to the University Amateur Showboat Theatre, also several rummage sales were conducted. Part of the money was given as a scholarship to an occupational therapy student attending the College of Puget Sound.

In September an occupational therapy recruitment and publicity display was exhibited in conjunction with the Washington State Health Council at the Western Washington Fair. Additional publicity was gained through an exhibit at the Washington Mental Health Association meeting.

The Washington Occupational Therapy Association was requested to participate in the program of the Association of Western Hospitals conference held in Seattle. A panel discussion "Occupational Therapy, Can You Afford to Be Without It?" was presented.

An interesting geriatric program was presented at a regular meeting by a panel from the hospital and nursing home section of the Washington State Health Department. Future planning includes creating positions for occupational therapists in the state nursing homes.

A wage scale survey of Washington State occupational therapists was conducted. This survey proved helpful in obtaining salary increases in several departments.

Regular monthly meetings are held from September through June each year with interesting programs planned for each meeting.

OFFICERS

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Under the auspices of the New York Medical College, the department of physical medicine and rehabilitation at Bird S. Coler Hospital is offering a two-week full-time course in geriatric rehabilitation. This course will be given from April 22 to May 3 for occupational therapists, registered nurses, and physical therapists. The curriculum covers physiologic, medical and psycho-social principles and practices of rehabilitation of geriatric chronically-ill persons.

The fee for the course is $100.00 and a small number of traineeships will be available. For information write:

Ira Belmont, Ph.D., Executive Assistant
Dept. of Physical Medicine and Rehabilitation
Bird S. Coler Hospital
Welfare Island, N. Y.

Reviews

FACTORS IN GROUP THERAPY, S. M. Tawadros, Ph.D. *International Journal of Social Psychology*, Vol. II, No. 1, Summer, 1956.

An analysis of factors in group treatment that are unique in this method and the factors common to both group and individual therapy. However, though the common factors were discussed, it was felt that "these processes are so altered by the dynamics of the group that they may—in cases—bear little resemblance to the original forms, and they operate, too, in a different location."

HEART DISEASE AT MID-CENTURY, Paul D. White, M.D. *Public Health Reports*, Vol. 71, No. 8, August, 1956.

A terse analysis and graph of heart disease as the leading cause of death at mid-century with a few pertinent remarks about the problems of the future.

PHYSIOLOGICAL APPROACH TO AMBULATION IN PARAPLEGIA, Edward E. Gordon, M.D., *Journal of the American Medical Association*, Vol 161, No. 8, June 23, 1956.

This study deals with the capacity for and limitation to ambulation in paraplegic patients, from the point of view of energy metabolism. Measurements included the rate of oxygen consumption, the amount of oxygen debt, and the concentration of lactic acid in the blood. Data from three types of paraplegic patients were compared to data from normally ambulant individuals.

The physiological evidence indicates that ambulation for certain paraplegics as a usual mode of progression is impractical, for severe physiological stress is incurred preventing the continuation of ambulation for any significant distance. This does not mean that standing and walking short distances either as exercise to maintain physiological balance or to carry out self-care activities is contraindicated.

Selection of paraplegic patients for full-scale ambulation should be on the basis of degree and locus of anatomic involvement; those with large trunk deficits will have doubtful success while those with involvement of only trunk flexors or with cord lesions below the twelfth thoracic or first lumbar vertebra will likely be successful. The factor of age also reduced work tolerance and capacity for effort. It is felt by the author that for the severely involved paraplegic patient the emphasis should be placed on the more constructive goal of vocational training in a wheel chair rather than on endless efforts at sustained ambulation. As a routine part of the rehabilitation program for these patients, the prohibitive metabolic price required renders ambulation unfeasible.

—D. R. Street, Lt. AMSC (OT)

THE TEAM APPROACH TO HEARING AND SPEECH DISORDERS, Robert Henner, M.D., R. J. Pollock, M.D., Peter Campanelli, M.A., Doris Phillips, M.D., Margaret Judiescl, M.A., *Journal of the American Medical Association*, Vol. 161, No. 10, July 7, 1956.

This article deals with the team approach in the habilitation of the "communicatively handicapped" child or adult, as practiced at the hearing and speech clinic of Michael Reese Hospital, in operation for the past three years.

Impairment of communication has extensive effects on

an individual, requiring numerous and varied services for a satisfactory solution of the resulting problems. The "global approach" is examined as it applies to the total patient. The roles of the members of the team are studied, that of the otologist, the clinical audiologist and speech pathologist, the medical social worker and clinical psychiatrist.

Early diagnosis is of extreme importance. An initial pediatric or medical examination is followed by otological survey, audiological and speech examination, social service study, and other special services as required (psychometric tests, psychiatric, neurological, orthopedic and opthalmologic consultations). A decision regarding the need for surgical or medical treatment is of first concern. Various types of special training and the use of a hearing aid when indicated may then commence. With the help of all these services, the handicapped individual is better able to accept and adjust to his condition and integrate himself into his environment.

—D. R. Street, Lt. AMSC (OT)

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 *for* 3 *lines; each additional word ten cents. (Average 56 spaces per line). Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

O.T.R.'s needed. The New York State Department of Mental Hygiene has a dynamic and expanding occupational therapy program which offers opportunities for initiative in active treatment services, participation in research, and experience in student supervision. Tuition available for advanced courses. Good promotional prospects. Beginning salary $4220. Write Virginia Scullin, O.T.R., Director of Occupational Therapy, 217 Lark Street, Albany, New York.

Registered occupational therapist—staff position—to direct department in new 169 bed accredited tuberculosis hospital. Benefits include paid vacation, sick, and holiday time. Liberal salary with insurance, retirement, and social security programs. Write William L. Mallory, Genesee County Tuberculosis Hospital, 702 Ballenger Rd., Flint, Michigan.

Staff position open for registered occupational therapist. Salary open. Pleasant surroundings and working conditions. Contact Dr. C. G. Ingham, Superintendent, Norfolk State Hospital, Norfolk, Nebr.

Occupational therapy director—salary $4704. Occupational therapists—salary $3456. Vacation and sick leave, retirement plan, and single room at nominal cost. Located in historic Williamsburg. Apply Personnel Office, Eastern State Hospital, Williamsburg, Virginia.

Immediate opening for registered occupational therapist in a general hospital. Challenging and interesting opportunities in a growing occupational therapy department. Good salary and opportunity for rapid advancement. Experience preferred but not required. Program includes functional and diversional therapy for pediatric and adult patients. Write to Dr. F. B. House, Director of Physical Medicine and Rehabilitation, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

Wanted—an occupational therapist for East Texas Treatment Center in Kilgore, Texas. Good salary and working conditions in a good town. Write or phone Mrs. Stuart Smith, Box 48, Price, Texas.

Occupational therapist with at least 1 year's experience, for position at children's convalescent and rehabilitation center. Well equipped department. All in-patient work with variety of diagnoses. Developing student training program. Position open immediately. Salary open. Write or call collect Children's Seashore House, Atlantic City, N. J., Dr. Harvey N. Vandegrift, Medical Director.

Wanted: registered occupational therapist for area treatment center. Almost new building, pleasant surroundings. Normal holidays plus regular and Christmas vacations, sick leave, hospital insurance available. Salary open. Practically all cerebral palsied child patients. Position available immediately. Write Donald H. Gerdom, Executive Director, Easter Seal Treatment Center, 2920 30th Street, Des Moines 10, Iowa.

Wanted: Registered occupational therapist to head department. Opportunity to use new ideas. For further information contact Jack A. Wolford, M.D., Superintendent, Hastings State Hospital, Ingleside, Nebraska.

Challenging position of section chief immediately available to registered OT, male or female, in progressive psychiatric hospital located 40 miles south of Kansas City. Require person with knowledge of human dynamics and experience in administering therapy to mentally ill patients. To function as a member of the psychiatric team and responsible for coordinating program including occupational, recreational, musical, and industrial therapies. Holiday, vacation, and sick leave benefits, maintenance available, semi-annual salary increases. Salaries $3888-$4980. Write to Robert O. Perry, Coordinator of Adjunctive Therapies, Osawatomie State Hospital, Osawatomie, Kansas.

Occupational therapist for 700 bed hospital to work primarily in the psychiatric section. Good salary, automatic increases, sick leave and vacation and retirement program. Contact H. J. Bearzy, M.D., Director, Department of Physical Medicine and Rehabilitation, Miami Valley Hospital, Dayton 9, Ohio.

Wanted: Two registered occupational therapists; one to head the department, in a modern 600 bed hospital for treatment of tuberculosis—social security and state retirement—liberal annual and sick leave privileges—salary $3264 to $4020—hospital located in college town of approximately 25,000 population. Apply: Eastern North Carolina Sanatorium, Wilson, N. C.

Senior Occupational Therapist: for progressive program in fully approved, non-sectarian, acute, general hospital. Our program includes functional and diversional therapy for pediatric and adult patients. Expansion program now underway will offer opportunity for work in rehabilitation unit. A minimum of one year's experience preferred. Liberal personnel policies. Salary open and commensurate with experience. Apply to Personnel Director, Mount Sinai Hospital, 1800 East 105th Street, Cleveland, Ohio.

Immediate opening for director of occupational therapy department. Salary open. Pleasant surroundings and working conditions. OT dept. now operating in the New Norfolk State Hospital Administration Building, with spacious quarters, new and modern equipment. Contact Dr. C. G. Ingham, Supt., Norfolk State Hospital, Norfolk, Nebraska.

VA Hospital, Iowa City, Iowa—immediately. Excellent position, 484 bed general hospital affiliated with State University of Iowa. Starting salary $4525. Further information from Manager, above address.

Immediate opening for staff OTR in crippled children's hospital and expanding comprehensive rehabilitation center treating multiple disabilities. Functional program for children and adults in well equipped department. Employee benefits and salaries in conformance with AOTA recommendations. Apply: Jack E. Pearson, Morris Memorial Hospital and Rehabilitation Center, Milton, W. Va.

Registered occupational therapist with experience and interest in physical disabilities, ADL, recreation. For information write: Personnel Section, Mayo Clinic, Rochester, Minnesota.

Wanted: A qualified occupational therapist for outpatient cerebral palsy center. 5 day week, 1 month vacation with pay, salary commensurate with experience. Write Dr. F. B. Kilgore, Ritter Building, Huntington, W. Va.

Occupational therapist: Senior position. Preferably 2 yrs. or more experience in cerebral palsy. Outpatient CP center for children and adults offering physical, occupational, and speech therapy; plus a part-time special education program. Annual four weeks paid vacation. Hours: 8:30-4:00, Monday through Friday. Salary open. Apply Miss M. M. Brossard, R.P.T., Coordinator, United Cerebral Palsy Treatment Center, 502 W. Mistletoe Ave., San Antonio 1, Texas.

Staff occupational therapists wanted immediately at Utah State Hospital, Provo, Utah. Working conditions are good and time-off provisions are liberal. Salary range $3720 to $4800 per year. Increases are based on merit. Applicants must be registered or eligible for registration. Please direct inquiry to Director, Rehabilitation Therapy, Box 270, Provo, Utah.

Wanted immediately: Director of occupational therapy and staff OT for county tuberculosis hospital. Bed capacity 300 adults, 15 children. Opportunity to work both in shop and on ward and with OT students. Salary ranges are $360 to $440 for director and $300 to $360 for staff plus laundry. Liberal vacation and retirement, excellent working conditions. Contact Personnel Dept., Benjamin Franklin Hospital, Columbus 7, Ohio.

Registered occupational therapists for supervisory positions with the California state department of public health in Berkeley. Salary range $6060 to $7356. Requires 4 years experience in occupational therapy work including 2 years in the field of cerebral palsy. Travel in assigned area to plan, organize and direct occupational therapy program for cerebral palsied and other physically handicapped children. Excellent fringe benefits, retirement annuities. Apply before March 21, 1957, for nationwide civil service examination. Write State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Wanted: staff occupational therapist for the Suburban Cook County Tuberculosis Sanitarium, Hinsdale, Illinois (suburb of Chicago). 170-bed hospital. Expanding program. Starting salary—$3,900.00 to $4,200.00, dependent upon experience. Two weeks vacation, 12 days sick leave, 11 holidays, plus other employee benefits. Maintenance available. Write to Miss Ellen Harenburg, O.T.R., 55th & County Line Road, Hinsdale, Illinois.

Staff positions are open for registered occupational therapists in hospitals under the City of St. Louis. One opening is in an 1100 bed general hospital; a second opening is in an 800 bed general hospital; a third opening is in a 600 bed tuberculosis hospital; and a fourth opening is in a 1600 bed chronic hospital. Pay range is $3944 to $4495 per year. Write to Department of Personnel, 235 Municipal Courts Building, St. Louis 3, Missouri.

Senior staff position for experienced occupational therapist having at least 2 years psychiatric experience to be in charge of adult patient groups in modern intensive treatment center. We are an instructing medical center attached to a medical school with training of more than 200 students per year. Minimum salary of $4200 per year depending on qualifications. Apply Personnel Director, University Hospital, Ann Arbor, Michigan.

Occupational therapist, for children's orthopedic hospital and rehabilitation center, located 32 miles from New York City, in Valhalla, New York. Salary open. Contact Mr. Jacob Reingold, Executive Director, Blythedale, Valhalla, New York, Telephone: LYric 2-7555.

New York City: Part time occupational therapist, need not be registered, to assist in OT program in private psychiatric hospital. Contact: Mr. J. Lebits, River Crest Sanitarium, Ditmars Blvd. & 26th Street, Astoria, N. Y.

State of Maryland has 2 openings in large mental hospitals in the Baltimore area for head occupational therapist. Excellent experience. Many benefits of Merit System appointment. Starting salary $4021 a year. Apply by March 9 to Comm. of Personnel, 31 Light St., Balto. 2, Md.

Wanted at Medical Center Hospital, Tyler, Texas: an occupational therapist to work with palsied and crippled children. Apply Mrs. Lourea Hickman, 1005 S. College, Tyler, Texas.

Vacancy for registered occupational therapist at Cerebral Palsy Center, Bergen County, N. J., available immediately, 30 hour week. 241 N. Van Dien Ave., Ridgewood, N. J.

Immediate placement for registered occupational therapists for rapidly expanding general medical, surgical, orthopedic and psychiatric departments. Holiday and vacation privileges, also liberal personnel policies, located in the largest centrally located medical and industrial center in Michigan. Above average beginning salaries, and opportunities for advancing to supervisor positions. For information write or wire collect to University of Michigan, University Hospital Personnel, Ann Arbor, Michigan.

Well established rehabilitation center for physical disabilities needs staff therapist. Progressive program includes functional treatment, ADL training and prevocational exploration. Located in teaching, research and medical center with 1,000 bed hospital. City rich in educational, cultural and recreational facilities. Forty-hour week with liberal time off provisions. Salary $3456-$4320. Position available after March 1, 1957. Write Dr. Herbert W. Park, Director, Physical Medicine and Rehabilitation, Medical College of Virginia, Richmond, Virginia.

California offers you attractive opportunities to participate in an expanding rehabilitation program in its state mental hospitals. Immediate employment for college trained recreation therapists, registered occupational therapists, and college trained music therapists. Salaries start at $4,296; good promotional opportunities. Three weeks paid vacation annually, retirement annuities and other employee benefits. Write State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

O.T.R. needed to work with physically handicapped and emotionally disturbed patients at institution for mentally retarded and epileptic. New OT building being constructed; full equipment and supplies; OT program medically oriented. University of Florida close by, offering social, cultural and educational advantages. Write to: Mr. R. C. Philips, Superintendent, Florida Farm Colony, Gainesville, Florida.

Occupational therapist—male or female. Immediate position open at the Cerebral Palsy Center, Louisville, Kentucky. Salary commensurate with experience. Contact Dr. Freeman P. Fountain, Associate Medical Director, United Cerebral Palsy of the Falls Cities, Inc., 120 East Gray Street, Louisville 2, Kentucky.

New York City: Position open for O.T.R. to head department in private psychiatric hospital. Modern OT building. Full maintenance if desired. Contact: Mr. J. Lebits, River Crest Sanitarium, Ditmars Blvd. & 26th Street, Astoria, N. Y.

Good opening for an occupational therapist who is able to carry general administrative responsibilities, including supervision of new intensive treatment units. Dynamic rehabilitation program requires candidate with good potential for teaching and supervising other occupational therapists, students and affiliates. Available to graduates of approved schools with two years experience. Salary $4740.00. Apply to William F. Green, M.D., Fairfield State Hospital, Newtown, Connecticut.

Male registered occupational therapists. Salary range $4980 to $6060. Openings at California State Vocational Institution at Tracy and Correctional Facility at San Luis Obispo. Requires completion of approved course in occupational therapy and one year of experience. Excellent fringe benefits, retirement annuities. Write California State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Registered occupational therapist for 250 bed convalescent hospital. Experienced in treatment of physical disabilities. U. S. citizen, under age 50. Salary range $415-519 plus vacation and holidays. Write to Medical Director and Superintendent, Tulare-Kings Counties Hospital, Springville, Calif.

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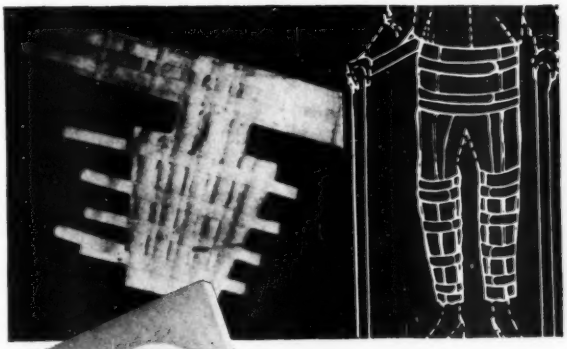

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